Unified School District 273

AUTHORIZATION FOR ADMINISTERING MEDICATION

Student's Name _____ Grade _____

Allergies _____ Date of Birth _____

TO BE COMPLETED BY THE PARENT/GUARDIAN

I am the lawful custodian of _____. I give my permission for him/her to take the below prescribed medication at school as ordered. I hereby acknowledge that I have read and understood the School Board Policies relating to the taking of medication. I hereby release the above school and its employees from any claims or liability connected its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the licensed prescriber.

_____ _____ _____

Parent/Custodian Signature | Daytime Phone | Date

Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container.

TO BE COMPLETED BY THE PHYSICIAN

Relevant Diagnosis _____

Action Plan for an Acute Episode _____

Prescribed Medication _____

Dosage _____ Route _____ Time(s) to be given at school _____

- ☐ Everyday at school
- ☐ Short term (List dates to be given) _____
- ☐ Episodic/Emergency Events ONLY

_____ _____ _____

Licensed Physician Signature | Daytime Phone | Date

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medication such as inhalers and EpiPens® **must** be authorized by the prescriber and be approved by the school nurse:

*Prescriber's authorization for self-carry/self-administration of emergency medication _____
(signature)

*School Nurse approval for self-carry/self-administration of emergency medication _____
(signature)

TO BE COMPLETED BY THE SCHOOL NURSE

School Nurse: _____ Date: _____