PRESCRIPTION AND AUTHORIZATION FOR MEDICATION ADMINISTRATION

When it is determined by the physician that medication must be taken during the school hours this form is to be completed.

Student_____ Date_____

Grade_____ Date of Birth_____ School_____

Allergies_____ School Year_____

PHYSICIAN'S ORDER or Clinic to provide a current computerized medication list to the school.

Medication_____ Dose_____ Route_____

Time /Frequency_____ Continue Until_____

Reason for Medication_____

Special Instructions_____

Major Side Effects_____

_____

Date_____ Physician Name (Print) _____

Physician Signature*_____

Phone_____ Address_____

*Physician signature on OTC medications is required only if dosage is not within the manufacturer's recommended guidelines.

Amount of Medication Received _____ Medication Expiration Date_____

I request this medication be given to my child in the manner specified herein. I give permission to school personnel to administer the medication. I understand that the administration of the medication will not necessarily be done by a nurse. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this medication. I further agree that the school personnel or nurse may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the administration of medications to the above named student from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described medications.

Date_____ Parent /Guardian_____

Phone (H)_____ Address_____

(C)_____ (W)_____