Melonie Queberg RN, BSN

Authorization for the Administration of Prescription Medication By School Personnel

Since medication for the student listed below cannot be scheduled for other than school hours and the administration of such medication may be supervised by medically untrained personnel, it is requested that theoral medication as indicated below be administered by school personnel.

Student Name _____ Date of Birth _____

School _____ Grade _____ Program _____

PARENT/ GUARDIAN SECTION

Please review the following steps required for permission of school personnel to administer anymedication to your child and sign this section:

1. Both the parent (top section) and the licensed prescriber (bottom section) must complete thisform.
2. Medication must be provided in the student's labeled prescription bottle. (The pharmacy mayprovide an extra bottle for long-term medication.) The prescription label must match the instructions from the prescriber. If it is a non-prescription medication, it must be in the original container.
3. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.
4. New forms must be submitted when there is a change in the original forms. (I.e. dose, time)

I request that medication be administered to my son/daughter according to the directions of the licensedprescriber in the following section. I also authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary by school personnel.

Signature of Parent _____ Date _____

Daytime Phone _____

LICENSED PRESCRIBER SECTION

I verify that this medication must be taken by: _____
Name of Student

Diagnosis (reason) for which medication is prescribed _____

Medication _____ Strength _____ Dose _____

Time medication is to be taken _____ Administration start date _____ Cease Date _____

Instructions or precautions, including possible side effects & storage _____

Licensed prescriber signature _____ Date _____

Licensed prescriber printed name _____ Phone _____

Student to self- carry and self-administer Epi-Pen _____ Date _____ Physician Initials _____