AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL BY SCHOOL PERSONNEL

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Principal's office.

STUDENT'S NAME____________________ DATE OF BIRTH____________________

PARENT/GUARDIAN____________________ HOME PHONE____________________

ADDRESS____________________ GRADE/SCHOOL____________________

EMERGENCY CONTACT NAME AND PHONE NUMBER: ____________________

I. TO BE COMPLETED BY THE PHYSICIAN

To be completed by the student's physician, physician assistant, or advanced practice nurse:

Name of Medication ____________ Administration Route________ Dosage____________

Time/Frequency/Circumstances when Medication Should be Administered ____________________

Possible Side Effect(s)____________________

Actions to be taken if the student has side effects and/or an adverse reaction to the medication:

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Intended Effects of this Medication____________________

Date of Prescription____________________ Discontinuation Date____________________

Other medications student is receiving: ____________________

Is it absolutely necessary that this medication be administered in school? Yes_____ No______

***The physician must authorize changes in dosage of any medications in writing.**

PHYSICIAN'S NAME (PRINT)	PHYSICIAN'S SIGNATURE	DATE	PHONE

II. TO BE COMPLETED BY THE STUDENT'S PARENT OR GUARDIAN

By signing below, I, ____________________, parent/guardian of ________________, confirm that I have reviewed and understand IPSD 204's Policy regarding the administration of medication in school. I understand that I am primarily responsible for administering medication to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize IPSD 204 and its employees and agents, on my behalf and in my stead, to administer or attempt to administer lawfully prescribed medication in the manner described above pursuant to State law.

practice. I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage or treatment is changed. I understand that this medication authorization is only effective for the current school year and will need to be renewed each subsequent school year.

Finally, I understand and agree that it is my responsibility according to IPSD 204 policy to deliver the legally prescribed medication to the school, and pick up any remaining medication at the end of the school year from the school, myself or via another adult designee.

Parent/Guardian Signature____________________ Date____________________