PARENTAL AUTHORIZATION AND RELEASE FORM
ADMINISTRATION OF PRESCRIPTION DRUGS TO STUDENTS

The undersigned are the parent(s), guardian(s), or person(s) in charge of

_____.
(name of the student)

It is necessary that the student receive (name of drug) _____, a physician-prescribed drug, during school intervals beginning on (date) _____ and continuing through_____. (date)

I hereby request that the School District, or its authorized representative, administer the drug named above to my child named above, in accordance with the prescribing physician's instructions, and agree to:

1. Submit this request to the teacher.
2. Make certain the Physician's Request for the Administration of Prescription Medication by School Personnel is submitted to the teacher.
3. Make sure personally that the drug is received by the teacher and/or county nursing service administering it, in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
4. Make sure personally that the container in which the drug is dispensed is marked with the drug name, dosage, interval dosage, and date after which no administration should be given.
5. Submit a REVISED STATEMENT signed by the physician prescribing the drug to the teacher IF ANY OF THE INFORMATION PROVIDED BY THE PHYSICIAN CHANGES.
6. Release the School District and the Board of Education of the School District and all employees, agents, and the representatives of the School District from any liability concerning the giving or non-giving of the drug to the student.

DATED this _____ day of_____, 20__.

_____
Parent/Guardian

ADMINISTRATION OF MEDICATION TO STUDENTS
PHYSICIAN'S REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICATIONS BY SCHOOL PERSONNEL

DATE _____

CHILD'S FULL NAME _____ is under my care and must take medication which I have prescribed during the school day.

Name of medication (as it appears on container in which the drug is stored)

_____

Dosage and time_____

Date administration of drug is to begin

_____

Possible adverse reactions to be reported to physician _____

_____

Special instructions for the administration and storage of the drug _____

_____

I or my designee(s) have trained school personnel or approved alternative training as adequate to administer the medication, have evaluated the situation, the general administration plan and if applicable, the self administration plan or emergency care plan, and deemed each to be safe and appropriate, and if applicable authorize the use of hypodermic syringes and needles or similar medical terms.

Name of Physician and Designee

_____

Print or Type

_____

Primary Phone Number

_____

Secondary Phone Number

_____

Signature of Physician