AUTHORIZATION OF STUDENT MEDICATION

2018-19 school year

I. the parent/guardian of___________________________ , DOB ___/__/__ , would like to request that medication be given to my child at school according to the directions specified below. I also release any and/or all school personnel from any liability that could be brought about by administering this medication as requested here.

Parent/Guardian____
(Please print name) (Signature) (Date)

	Medication to be given	Dosage (mg)	Time to be Given	Diagnosis
1				
2				
3				

YES/N0

_______Would this medication be dangerous if taken by any person other than the one for whom it was prescribed?

_______ Should this medication require storage under refrigeration?

_______ Should this medication be kept in a locked container?

_______ Would this medication prevent the child from participation in field trips or other school activities?

_______Is any of this medication specifically for seizure control?

Circle the medication that the student carries with them at all times: Asthma inhaler. Epi Pen. Diabetic insulin (to be taken by an insulin pen. A health plan must be in place to administer insulin).

Any specific instructions to the school

____

____

____

____ ______________________________

Doctor's Name (please print) Phone#

THIS AUTHORIZATION IS IN EFFECT FOR THIS SCHOOL YEAR, A NEW FORM MUST BE SIGNED EACH YEAR