Medication Authorization Form

Name of Student _____

Name of Parent/Guardian _____ Day Time Phone # _____

Emergency Contact if parent is unavailable:

_____ Phone # _____

MEDICAL CONDITION(S) _____

(For example: Asthma, diabetes, severe allergies, seizures, etc.)

NOTE: ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER.

NON-PRESCRIPTION/OVER-THE-COUNTER MEDICINES to be administered at school

Name of Medication	*Dosage*	*Times/Frequency*
_____	_____	_____
_____	_____	_____

PRESCRIPTION MEDICATIONS to be administered at school

Name of Medication	*Dosage*	*Times/Frequency*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

In order for a student with asthma, allergies or diabetes to carry and self-administer his/her prescribed medication, a licensed healthcare provider must provide a statement confirming that the student is able to self-administer the medication listed on this form.

If the student is seeking diabetes care at school, a diabetes medical management form signed by the licensed healthcare provider must be attached.

Please list any special instructions: _____

I hereby release and agree to hold harmless and indemnify the School District and any of its employees or agents from any liability whatsoever occasioned by the administration or non-administration of the above described medication to my child during school hours in accordance with the above instructions.

I further authorize the prescribing physician to discuss with the principal or his/her designated staff member any matter regarding the medication to be administered.

Signature of Parent/Guardian _____ Date _____