Choctaw County School District

Authorization for Medication Administration

Healthcare provider to complete top portion*

Name of Student: _____ Date of Birth: _____ Grade: _____

Name of School: _____ School Year: _____

Name of healthcare provider ordering medication: _____

Contact information of healthcare provider (phone, address):_____

_____

Medication:_____

Name: Dosage: Route: Frequency/Time:

Reason for medication (medical diagnosis):_____

Healthcare provider signature:_____ Date:_____

Parent/Guardian Ageement

- I give permission to the school nurse to administer the above medication to my child according to the written healthcare provider orders. If deemed appropriate, the nurse may delegate this nursing task to unlicensed assistive personnel who have received training and an evaluation of competence and have agreed to ongoing supervision by the nurse.

- I also give permission to the school nurse to:

  -Release information related to the medical condition to the prescribing healthcare provider.

  -Request information from the prescribing healthcare provider.

- I further agree to hold the Choctaw County School District harmless in any or all claims arising from the administration of this medication.

I agree to the following responsibilities regarding medication administration:

1. The first dose of a newly prescribed medication should be given at home.
2. Prescription medication must be in the original container labeled by the pharmacist.
3. Non-prescription medication must be in the original container with the label intact.
4. Any medication to be given at school must be brought in by the parent or guardian. Do not send any medication to school with your child.
5. At the end of the school year, the parent or guardian must pick up medication from the school.

Parent/Guardian signature*:_____ Date:_____*