## Mt. Vernon Township High School

# Authorization and Permission for Administration of Medication

Return or **FAX to the Nurse Office at 618-246-1767**

**Student Name** _____ Birth Date _____ Class _____
(Last) (First) (Initial)

*Medication* **Allergies** _____

## Parental Authorization:

I, the parent/guardian of _____, a student at Mt. Vernon Township High School District #201, hereby acknowledge that I am primarily responsible for administering medication to my child. However, during school hours when I am unable to administer or in the event of an emergency, I hereby authorize Mt. Vernon Township High School District #201 and its employees, on my behalf, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of the school district), the following named prescription medication, non-prescription medication or over-the-counter medication following manufacturer's guidelines or prescription medication as ordered by the physician.

I acknowledge that prescription medications, non-prescription medication or over-the-counter medication will be administered by or under the supervision of the certified school nurse, parent, or administrative staff, and specifically consent to such practices. I further acknowledge and agree that, when the medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees, and School Board/Administration arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and School Board/Administration, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

I have read, understand and agree to the regulations concerning administration of medication at school. I agree to the release of health information between school and physician.

***Parent/Guardian Signature*** _____ ***Phone*** _____

## Physician Authorization:

| _____ | _____ | _____ |
|---|---|---|
| **Medication to be given** | **Dosage/Route** | **Time to be administered** |

Administration instructions: _____

Diagnosis requiring medication: _____

Intended effect of this medication: _____

Expected side effects: _____

Other medications student is taking: _____

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Prescriber's Name** | ***Prescriber Signature*** | **Date** | **Prescriber's Phone #** |