USD 311 Pretty Prairie

AUTHORIZATION FOR MEDICATION TO BE ADMINISTERED AT SCHOOL

Part A - Parent to Complete

Name of Student: ___________________________ Date of Birth: ______________ Grade/Teacher: _______________

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school or on a field trip as indicated by my child's health care provider as described in Part B listed below.

I understand that it it my responsibility to provide all medication in its original container. I further understand that any school employee who administers any medication pursuant to parental written request to my student in accordance with written instruction from the physician shall not be liable for damages as a result of an adverse medication reaction.

I also give permission for communication between the school and the medical prescriber and dispensing pharmacy related to the specific medication/treatment in question, including communication concerning:

1. the prescription or treatment itself – i.e., questions regarding dosage, method of administration, and potential drug interactions.
2. implementation of the treatment in school – i.e., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule.
3. student outcomes from the treatment – i.e., questions regarding observed side effects, possible negative reactions, observations of behavior changes in the classroom.
4. other pertinent issues related to the student's diagnosis, condition, or treatment.

__________________________ __________________________ __________________________
Parent /Legal Guardian Signature | Printed Name of Parent /Legal Guardian | Today's Date

__________________________ __________________________
Home Phone | Cell Phone

Part B - Health Care Provider to Complete

MEDICATION AND/OR TREATMENT ORDERS: (please specify)

Medication / Treatment	Dosage / Route	Time / Frequency	Diagnosis(es) / Indication

Special Instructions: ____

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__________________________ __________________________ __________________________
Signature of Physician/APRN/PA | Printed Name of Physician/APRN/PA | Name of the Supervising Physician **for APRN/PA**

__________________________ __________________________ __________________________
Health Care Provider Phone Number | Health Care Provider FAX Number | Today's Date

This student has demonstrated the skill level necessary to self-administer such medication/treatment.

☐ **Yes** __________________________ __________________________
Signature of Physician/APRN/PA | Medication(s)/Treatment(s) that can be self-administered