Student Medication Authorization Form

Student's Name:_____ Birthdate:_____

To be complete by the child's parent(s)/Guardian(s). This form is to be used for medication other than medical cannabis. A new form must be completed every school year for each medication. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Parent_____

Phone:_____ Emergency Phone:_____

School: **Annawan Unit District 226** Grade: _____ Teacher: _____

All medications to be taken at school must be brought to the nurse or principal's office by a parent or other responsible adult. The prescription medication is to be in a container appropriately labeled by the pharmacy or the physician with the student's name, name of drug, dosage, and time intervals in which the medication is to be taken. The non-prescription medications must be brought to the nurse's office in the manufacturer's original packaging.

I thereby request and grant permission for Annawan Unit 226 and it's personnel to dispense or to administer prescribed medications or treatments to my ☐ son ☐ daughter , _____(print student's name) according to _____(print Provider's Name). I further release and waive any claims against the school district, it's employees, and agents arising out of the administration of said medications/treatments and agree to hold harmless and indemnify the School District, it's employees and agents , either jointly or separately, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorney's fees, resulting from or arising out of the administration of medication or treatments to my child by school personnel.

Parent/Guardian signature_____ Date _____

To be completed by student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority.

Prescriber's Printed Name: _____

Office Phone: _____ Emergency Phone:_____

Medication Name: _____

Is it necessary for this medication to be administered during the school day? **Yes ☐ No☐**

Dosage: _____ Frequency: _____ ☐ PRN

Time medication is to be administered or under what circumstances/ Purpose: _____

Prescription Date:_____ Order Date: _____ Discontinuation Date: _____

Expected side effects if any: _____ Time intervals for re-evaluation: ☐ PRN ☐_____

Other Medications student is receiving: _____

Prescriber's Signature: _____ Date: _____