GEORGETOWN-RIDGE FARM #4 CUSD

Success for today. **Preparation** for tomorrow. **Learning** for a lifetime.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION School Year _____

The following information is required for prescription or non-prescription medications at school and must be renewed annually.

1. The parent/guardian portion of form below must be completed.
2. The licensed prescriber portion of form below must be completed.
3. The completed form below must be on file at the school before the medication can be administered at school.
4. The medication must be in the original labeled container as dispensed or in manufacturer's labeled container and must contain student name, medication name, directions for use, and date.
5. Parents or other authorized adult must transport medication and supplies to and from school; students may not carry medications.
6. All unused medications not picked up by parents by end of school year will be destroyed by nurse in accordance with policy.
7. Immediate written notification of changes must be provided to the school by the parent/guardian.
8. For the safety of your child, scheduled medications are not routinely administered at school on 11:15 dismissal days due to the shortened schedule.

NO MEDICATION WILL BE ADMINISTERED AT SCHOOL IN THE ABSENCE OF A COMPLETED, APPROVED AUTHORIZATION FORM

TO BE COMPLETED BY PARENT OR GUARDIAN (Please Print)

Student's Name: _____ Date of Birth: _____ School: _____ Grade/Teach: _____

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, in my behalf, to administer, attempt to administer to my child, or allow my child to self-administer pursuant to State Law while under the supervision of the School District and its employees and agents, lawfully prescribed medication in the manner outlined on this form. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices.** I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct arising out of the administration or the child's self-administration of medication. I further acknowledge and agree that when lawfully prescribed medication is so administered, or attempted to be administered, I waive any claims that I might against the School District, its employees and agents arising out the administration of said medication. In addition I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, 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.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Home Telephone Number: _____ Work Number: _____ Cell Number: _____

TO BE COMPLETED BY LICENSED PRESCRIBER

Child's Name (please print): _____ Diagnosis: _____

Medication: _____ Dosage: _____

Route of administration: _____ Frequency: _____

Time of Administration and/or under what circumstances* : _____

Diagnosis Requiring Medication and reason it must be given during school hours: _____

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

Intended Effect: _____

Possible Side Effects: _____

Other medications student is receiving: _____

Time Interval for Re-evaluation: _____

Physician's Printed Name: _____

Physician Signature: _____

Office Phone Number: _____

Emergency Phone Number: _____

Date: _____

FOR SCHOOL HEALTH OFFICE USE ONLY

_____ Approved _____ Denied Reason for Denial: _____

Signature of Nurse or Administrator: _____

AUTHORIZATION FOR MEDICATION ADMINISTRATION- ALTERNATE SCHEDULING School Year: _____

AND/OR STUDENT SELF-CARRY/ SELF-ADMINISTER (*ASTHMA INHALER/ EPINEPHRINE AUTOINJECTOR ONLY*)

The following information is required for prescription or non-prescription medications at school and must be renewed annually.

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1. The parent/guardian portion of form below must be completed.
2. The medication must be in the original labeled container as dispensed or in manufacturer's labeled container and must contain student name, medication name, directions for use, and date.
3. Parents or other authorized adult must transport medication and supplies to and from school; students may not carry medications other than those approved asthma inhaler and/or epinephrine autoinjector with completed paperwork and action plans on file.
4. All unused medications not picked up by parents by end of school year will be destroyed by nurse in accordance with policy.
5. Immediate written notification of changes must be provided to the school by the parent/guardian.
6. To allow for appropriate medication administration by the school nurse, medications should be ordered in accordance to each building's scheduled "staggered station times" as outlined by the School District. Pine Crest medications will be given at 11am, MMJH at 11:45am, and GRHS at 12:30pm.
7. For the safety of your child, scheduled medications are not routinely administered at school on 11:15 dismissal days due to the shortened schedule.
8. Students requiring medication administration outside of outlined policy must have a completed "Alternate Scheduling" form on file at the school.

NO MEDICATION WILL BE ADMINISTERED AT SCHOOL IN THE ABSENCE OF COMPLETED, APPROVED AUTHORIZATION FORMS

Student's Name:_____ Date of Birth: _____ School: _____ Grade/Teach: _____

Diagnosis: _____ Medication: _____

Dosage: _____ Route of administration: _____ Frequency: _____

Please allow for staggered station times whenever possible: Elementary School- 11am, Junior High- 11:45am, High School- 12:30 pm

Time of Administration and/or under what circumstances*:_____

Medical reason medication must be given outside of specified building station times: _____

Medical/personal reason medication must be given during early dismissal days: _____

Parent/Guardian Signature: _____ Date: _____

Prescriber Signature: _____ Date: _____

For Self-Carry and self-administer of Asthma and/or epinephrine autoinjector:

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, in my behalf, to administer, attempt to administer to my child, or allow my child to self-administer pursuant to State Law while under the supervision of the School District and its employees and agents, lawfully prescribed medication in the manner outlined on this form. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices. I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct arising out of the administration or the child's self-administration of medication. I further acknowledge and agree that when lawfully prescribed medication is so administered, or attempted to be administered, I waive any claims that I might against the School District, its employees and agents arising out the administration of said medication. In addition I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, 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.

***Student to be allowed to self-carry asthma inhaler or epinephrine autoinjector:** _____YES _____NO

***Student to be allowed to self-administer asthma inhaler or epinephrine autoinjector:** _____YES _____NO

Parent/Guardian Signature: _____ Date: _____

Prescriber Signature: _____ Date: _____

Comments:

** Attach current prescription label of asthma inhaler or epinephrine autoinjector that will be self-carried/administered by student in this section or on back of form**

_____

_____

_____

_____

_____

FOR SCHOOL HEALTH OFFICE USE ONLY

Date Received _____ Approved _____ Denied_____ Reason for Denial: _____

Signature of Nurse or Administrator:

_____