Authorization to Assist Competent Student with Administration of Medication

Medication shall be administered only when the student's health requires that it be given during school hours. It is the parent/guardian's responsibility to BRING this medication to school and REMOVE any unused medication when treatment is completed.

All prescription medication must be brought to school by the parent/guardian in the original container. The pharmacy label must include the following information:

Name of Student
Prescription Number
Name and Dosage of the Medication
Administration Route or other Directions
Date
Licensed Prescriber's Name
Pharmacy Name, Address, and Phone Number

Licensed Prescriber's Signature is required for all Prescription Medication
No more than one month's supply of any medication should be brought to school.

All non-prescription medication must be brought to school in the original manufacture's unopened, labeled container with the ingredients listed and the child's name affixed to the container. Dosage must be appropriate for child's age.

Parent/Guardian and Licensed Health Care Providers (HCP) Authorization

Student Name_____ **School**_____ **Date**_____
I request that school personnel assist the above named student to self-administer the following medication while in school and away from school activities.

Name of medication:_____ **Amount of med to be taken:**_____

Time(s) medication is to be taken: _____ **Route:**_____

Date last dose if medication is to be taken: _____

Reason Medication is needed at school: _____

Possible side effects: _____

***Signature of Prescriber (prescription medications)**_____

Printed name of Physician/HCP: _____**Phone:** _____
Date_____

It is understood that the medication is administered solely at the request of, and as an accommodation to the undersigned parent/guardian. In consideration of the acceptance of the request to perform this service by any trained person by the school nurse and employed by Gibson County School District, the undersigned parent/guardian hereby agrees to release the Gibson County School District and its personnel from any legal claim they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student. Parent will assume full responsibility for any effect and complications that my child may have as a result of taking this medication.

Parent/Guardian Signature:_____ **Date:**_____

Parent/Guardian Name:_____ **Phone Number:**_____

Comments:_____