PARENTAL AND PHYSICIAN AUTHORIZATION AND RELEASE FORM
ADMINISTRATION OF PRESCRIPTION MEDICINE TO STUDENTS

Child's Full Name:______________________________________ Birthdate:____________

Name of Medication:____________________________________
(As it appears on container in which the drug is stored)

Dosage:____ Route:______________

Time to be given:____

Date administration of drug is to begin:_______________________________

Possible adverse reactions:____

Special instructions for the administration and storage of the drug:____________________________

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I hereby request that the School District, or its authorized representative, administer the drug named above to my child named above, in accordance with the prescribing physician's instructions, and agree to:

1. Submit this request to the school office.
2. Make certain the Physician's Request for the Administration of Prescription Medication by School Personnel is submitted to the school office.
3. Make sure personally that the drug is received by the office, in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
4. Make sure personally that the container in which the drug is dispensed is marked with the drug name, dosage, interval dosage, and date after which no administration should be given.
5. IF ANY OF THE INFORMATION PROVIDED BY THE PHYSICIAN CHANGES, submit a REVISED STATEMENT signed by the physician prescribing the drug to the office
6. Release the School District and the Board of Education of the School District and all employees, agents, and the representatives of the School District from any liability concerning the giving or non-giving of the drug to the student.

DATED this _____ day of____________________, 20__. ___________________________
Parent/Guardian Signature

TO BE COMPLETED BY PHYSICIAN (FOR PRESCRIPTION MEDICATIONS ONLY)

I or my designee(s) have trained school personnel or approved alternative training as adequate to administer the medication, have evaluated the situation, the general administration plan and if applicable, the self-administration plan or emergency care plan, and deemed each to be safe and appropriate, and if applicable authorize the use of hypodermic syringes and needles or similar medical terms.

Name of Physician or Designee

Print or Type______________________________ Primary Phone Number______________________

Signature of Physician______________________ Secondary Phone Number____________________