Authorization for Medication Administration

Student Name: _____ Date of Birth: _____ School: _____

Allergy(ies): _____ School Year: _____ HR Teacher:_____

Parent/Guardian Name: _____ Phone: Home_____Work_____

*ANY MEDICATION THAT IS TO BE ADMINISTERED AT SCHOOL MUST BE BROUGHT TO SCHOOL BY A PARENT OR GUARDIAN, NOT THE STUDENT. SPECIAL SITUATIONS SHOULD BE DISCUSSED WITH THE PRINCIPAL.

I. OVER THE COUNTER MEDICATION CONSENT ***(If over-the-counter medication is to be given for more than five days, the doctor or nurse practitioner must complete section II. PRESCRIPTION MEDICATION CONSENT below.***

Over-the-counter medication: _____.

Times to administer: _____. Dosage to administer: _____

Reason to administer: _____

II. PRESCRIPTION MEDICATION CONSENT (to be completed by doctor or nurse practitioner)

Relevant Diagnosis: _____

(1) Medication: _____ Dosage & Time: _____ Route: _____

(2) Medication: _____ Dosage & Time: _____ Route: _____

(3) Medication: _____ Dosage & Time: _____ Route: _____

It is preferred that medications be given before or after school. Could this medication be given before or after school?
_____ Yes, and parent has been instructed. _____ No, (explain) _____

If medication is PRN, episodic/emergency events only, please explain _____
_____

Side effects/warnings: _____

DOCTOR OR NURSE PRACTITIONER:
Print Name _____ Signature: _____

Phone: _____ Date: _____

PARENTAL CONSENT FOR ANY MEDICATION ***(Must be completed for over-the-counter and/or prescription medication)***

I am the parent or guardian of: _____. I give my permission for him/her to take the medication(s) listed above while at school:

I hereby acknowledge that I have read and understand the School Board policy for administering medication(s) to students at school. I am aware all prescription and non-prescription medication(s) must be in an original labeled container or it cannot be given. In the absence of the school nurse, medication, including insulin, glucogen, and epipen, if prescribed, may be administered by trained non-medical school employees, and I state, without reservation, that I shall not hold him/her or the Floyd County School Board liable in any way for harm or injury that may be experienced by my child as a result of this service.
I hereby release Floyd County Schools and its employees from any claims or liability connected with its reliance on this permission and agree to release, defend, and hold them harmless from any claim or liability connected with such reliance.
I authorize a representative of the school to share information regarding this medication with the medical provider.

Parent/Guardian signature: _____ Date: _____

NOTICE: THIS AUTHORIZATION IS ONLY VALID FOR ONE SCHOOL YEAR.

FCSD Rev. May, 2008