LUCK SCHOOL DISTRICT MEDICATION AUTHORIZATION FORM

Note: Each medication requires a separate form

Parent completes this section for ALL medication:

Student _____ Birthdate _____

Teacher _____ Grade _____

Medication _____ Dose _____

Route/Mode of administration _____ Frequency _____ Duration _____

Times to be given _____ Start date _____ Stop date _____

Potential Adverse Reactions _____

If PRN (as needed) state condition under which school personnel should administer medication (i.e. Headache, fever, pain, cough, etc…) _____

Physician Name _____

I hereby give permission for appropriately trained personnel to give this medication to my child according to the directions stated. I also authorize school personnel designated in medication administration to contact my child's practitioner or me if there is a question regarding medication administration. I agree to notify the school when the drug is to be discontinued and/or if the dosage or time changed. I understand that if the medication is resumed, a new medication authorization form is required. I understand that any unused medication will be properly disposed of if not claimed within 10 days after discontinuation of the medication. I agree to hold the School District, its employees and agents, excluding healthcare professionals, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

X_____ Date _____

(Parent or Guardian Signature)

Home phone _____ Work phone _____

Physician completes this section for prescription medication:

I acknowledge by my signature on this document that I will assist and advise designated school personnel with regard to the administration of medication described below, which includes accepting direct communication. I further acknowledge that all instructions should be stated in language of the layperson. I further understand that if a student is allowed to self-administer medication, that proper instruction has been given.

Diagnosis/Reason for medication _____

Medication _____ Dose _____

Route/Mode of administration _____ Frequency _____ Duration _____

Times to be given _____ Start date _____ Stop date _____

Special instructions for administration _____

Potential adverse reactions (if noted, school personnel should contact parent/guardian/or physician) _____

Student *may* _____ *may not* _____ carry and/or self-administer emergency meds (i.e. Epi-pen, Glucagon, Inhalers) at school.

_____ _____

(Practitioner Signature) (Phone number)

_____ _____ _____

(Practitioner name) (Date) (Clinic name)