

Paola USD #368
Authorization for Medication

Name of Student _____
School _____ **Grade** _____ **Teacher** _____
Medication _____ **Dosage** _____
Time of Day Medication is to be given _____ **Date Med. Started** _____
Anticipated Side Effects _____
Diagnosis/Reason for Medication _____

I hereby give my permission for _____ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I hereby release the school district and personnel from any liability for damages as a result of an adverse reaction to this medication, and acknowledge that the school bears no responsibility for ensuring the medication is administered. I hereby authorize the USD #368 District Nurse to exchange information regarding this request with the prescribing health care provider and with the pharmacy as identified on the affixed pharmacy label if clarification is required.

Signature of Parent/ Guardian _____ **Date** _____
Printed Name of Parent/ Guardian _____ **Phone** _____

Date _____ **Signature of Physician (for prescription meds only)** _____
Name of Physician _____
Address _____
Phone # _____

NOTE: Prescription medications are to be brought to school by the parent, in the newest original container and/or appropriately labeled by the pharmacy; stating the child's name, name of the medication, the dosage and times to be administered. This form must be signed by the prescribing physician or attach physician signed note with same information as listed above.

Grades 6-12 ONLY: () Student may carry above listed inhaler, Epi-Pen, or insulin injection with him/her at all times to be used as directed by physician. Please indicate parental approval by placing a check mark in the parentheses, complete this form and turn it in to your child's school. **Physician's signature is required.**

Medication Count

Date	Amount Received	Supplied By	Amount Returned	Taken By	Staff Initial