SCHOOL MEDICATION AUTHORIZATION/IHSP

TO BE COMPLETED BY PARENT BEFORE GIVING FORM TO DOCTOR

I request that my child, _____, be assisted in taking the above prescribed medication at school by authorized persons. I will comply with the school's policies and procedures. I agree to, and do hereby hold the District and its employees harmless from any and all claims, demands, causes of action, liability or loss of any sort because of, or arising out of, the acts or omissions of the District or its employees with respect to this medication.

I authorize exchange of information between my child's physician, school district nurse, teacher(s), and principal.

Parent Signature _____ Date _____ Home Phone _____ Emergency Phone _____

Address _____ Name of medication _____ Time to be given at school _____

Student's Name _____ DOB _____ School _____ Phone _____ FAX _____

PHYSICIAN'S ORDER (TO BE COMPLETED ONLY BY PHYSICIAN)

ONLY ONE MEDICATION PER FORM

Name of Medication _____ Strength _____

Dosage _____ Dose form (tablet/liquid, etc.) _____ How often? _____

Time to be given at school _____

Reason for medication _____ Possible side effects _____

☐ Student has been instructed by physician in the use of inhaler and may carry medication with them.

☐ Student has been instructed by physician in the use of the EPI-PEN and may carry the medication with them.

Comments _____

The pupil for whom this medication is prescribed is under my care.

LICENSED PHYSICIAN PRINTED NAME _____ LICENSED PHYSICIAN SIGNATURE _____ DATE _____

ADDRESS _____ PHONE _____

SCHOOL OFFICE STAFF USE ONLY

MEDS CALENDARED ☐ BY _____ DATE _____ | TIME _____