

***Complete this form only if medication is to be given during the school day.
5330F1**

**AUTHORIZATION FOR MEDICATION
(Page 1 of 2)**

To the Parent/Guardian or the Adult Student:

The following information is necessary for any student to use medications in school. **All spaces must be completed and accompanied by page two, the physician statement.**

We are also notifying you of a new state law, Senate Bill 376. This law allows students with a severe or chronic illness, such as asthma, or severe allergic reactions to carry and self-administer medication provided they have parental and physician's permission.

Name of Student _____ Telephone _____
Address _____ Date of Birth _____
School _____ Teacher/Room _____

1. I am requesting permission for my child named above to: (check those which apply)

- _____ Use or receive medication
- _____ Carry emergency medication
- _____ Self-administer emergency medication

2. I will assume responsibility for safe delivery of the medication to school by me. Yes _____ No _____

3. I will notify the school immediately if there is a change in the use of the medication. Yes _____ No _____

4. I release and agree to hold the Board of Trustees, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization. Yes _____ No _____

Signature of Parent/Guardian or Adult Student Date

Home Telephone Work Telephone

The following items must be signed by parent:

I have read and understand that Senate Bill #376 allows my child to carry emergency medication with physician and parent/guardian permission. Signature of Parent/Guardian/Adult Student _____

I give permission to the school to contact my doctor with any questions about medications and/or treatments.

Signature of Parent/Guardian/Adult Student _____

PHYSICIAN STATEMENT
(Page 2 of 2)

To the Physician:

The Board of School Trustees urges you to schedule, to the extent possible, medication of a student outside of school hours. When that is not possible, medications will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I have prescribed the following to be administered to _____

Student Name

Medication _____ Dosage _____

Medication is to be taken at the following times _____

Instructions or precautions (including possible side effects): _____

Beginning Date _____ Expiration Date _____

Emergency Medication _____

Indication (Please specify exact directions for "when needed") _____

Other information: _____

May student self-carry & self-administer emergency medication? ___ Yes ___ No

Physician Signature _____ Date _____

Printed Name _____ Telephone/Fax _____