Authorization for Medications/Procedure to be Administered School, Field Trips, and Extracurricular

Parent/Legal Guardian to Complete

Name of Student: ______________________________________ Date of Birth: _______________ Grade/Teacher: _______________

Prescribing Physicians Name: ____ Phone Number: _______________________________

I grant permission for the school nurse or a delegated staff member to administer medications/treatment to my child at school as indicated by my child's physician accordingly below. I understand that I must provide any prescribed medication in its original labeled container.

I also acknowledge the need and give permission for appropriate communication between the school health professional and the medical prescriber related to the specific treatment in questions, including communication concerning: 1. The prescription or treatment itself (e.g. questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube); 2. Implementation of the treatment in school (e.g. questions regarding safety concerns, infection control issues, or medications in the treatment order related to the school setting or students' academic schedule); 3. Student outcomes from treatment (e.g. questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom); 4. And other pertinent issues related to the student's diagnosis, condition, or treatment.

I understand the policy of the Board of Education of USD 250 will keep individual record of each medication administered, any changes to prescribed medication (e.g. type of medication, dosage, and/or time of administration) should be accompanied by a new Authorization for Medications/Procedure to be Administered at School, Field Trips, and Extracurricular Activities form and a newly labeled container. In the administration of medication, the school employee shall not be deemed to have assumed any legal responsibility other than acting as a duly authorized employee of the school district.

____________________________________ ____________________________________ ______________________

Parent/Legal Guardian Signature | Parent/Legal Guardian (Printed Name) | Date

Physician to Complete

Current Diagnosis (es): ___________________, ___________________, ___________________, ___________________

<u>PHYSICAN MEDICATION AND/OR TREATMENT ORDERS</u>: (please specify)

Medication/Treatment	Dosage	Time/Frequency
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________

Special Instructions: ____

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____________________________________ ____________________________________ ______________________

Physician/Midlevel Signature | Physician/ Midlevel (Printed Name) | Date