***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 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 it's employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization. Yes_____ No_____

_____ _____
Signature of Parent 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 permission. X _____

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

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

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_____