Medication/Procedure Authorization to be Administered at School and Field Trips

USD 470 Arkansas City Public Schools

Name of Student: _____ Date of Birth: _____ Grade: ____

Part A: Parent/Guardian to Complete

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

I also acknowledge the need and give permission for appropriate communications between the school nurse and the medical prescriber related to the specific treatment in question, including communication concerning: 1. The prescription or treatment itself (such as 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 treatment in school (such as questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule); 3. Student outcomes from the treatment (such as questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom); and 4. And other pertinent issues related to the student's diagnosis, condition or treatment.

_____ _____ _____

Parent signature Parent printed name Date

Part B: Physician/Dentist to Complete

Current Diagnosis(es): _____ _____ _____

Physician Medication and/or Treatment orders: (Please specify)

Medication/Treatment	Dosage	Time/Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special Instructions: _____

_____ _____ _____

Physician signature Physician printed name Today's date