Title: Parental Authorization and Release Form for the Administration of Medication to Students

Prescription Medication Authorization

Student's Name: _____

Date of Birth_____

School: _____ Grade: _____ Teacher: _____

Drug Allergies/Reactions: _____

Parent/Guardian Authorization

The Council Bluffs Community School District encourages that medication be taken at home before school hours or after school when possible. However, when necessary, students will be assisted with self-administration of medication or administer medication according to Council Bluffs Community School District policy.

- **Prescription medication will only be given if prescribed by an authorized prescriber (MD, DO, NP, PA).**
- **Permission must be given to the school staff through the completion of this form.**
- **Medications stored in envelopes, baggies, etc. will not be administered.**
- **Medication must be delivered to the school by a responsible adult in the container in which it was dispensed as ordered by prescribing physician. Pharmacist can provide a duplicate labeled container with only the school doses.**
- **A separate permission form is required for each medication to be given.**
- **Parents are responsible for noting the expiration date of all medication. Expired medication will not be given at school.**
- **Any medication not picked up by the last day of school will be destroyed according to the school districts guidelines.**

I hereby grant my permission to the principal or designated staff member to administer or assist my child with the self-administration of the medication listed below and a record be maintained in accordance with the Medication Policy of Council Bluffs Community School District. The student has experienced no previous side effects from the medication.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinary reasonably prudent person would under the same or similar circumstances.

I authorize the prescribing named physician to discuss with the principal or designated staff member any matter regarding the medication to be administered.

I understand that it is my responsibility to inform the school of any medication changes. New medications or new doses **will not** be given unless a new Prescription Medication Authorization is completed.

_____	_____	_____	_____
Parent/Guardian Signature	Date	Home Phone	Work Phone

Approved: May 23, 2006 Reviewed: May 10, 2016 Revised: April 26, 2011
January 28, 2020

Council Bluffs Community SCHOOL DISTRICT

Student's Name: _____
Date of Birth_____
School: _____ Grade: _____ Teacher: _____
Drug Allergies/Reactions: _____

Prescriber Authorization

COMPLETED BY PRESCRIBER

Name of Medication_____
Dosage_____ Frequency/Time to be given_____
Form of Medication/treatment: ☐ Tablet/Capsule ☐ Liquid ☐ Injection ☐ Nebulizer ☐ Other_____
Reason for medication: _____

Stop Medication: ☐ End of school year ☐ One year from date written
☐ Other date/duration_____

Child may carry medication during the school day due to a life threatening condition: ☐ Yes ☐ No

Restrictions/Special Instructions/Important Side Effects:_____
_____

Name of Prescriber: _____ Phone:_____
Address: _____ Fax: _____

Prescriber's Signature _____ Date: _____

Health Services Signature: _____ Date:_____