Carlynton School District

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

(Prescription and Over-the-Counter)

DATE: _____ Child's GRADE: _____

Child's NAME: _____ must receive the following medication during school hours in order to maintain sufficient health to participate in the school program. All medication must be in the original manufacturer's container or the pharmacy labeled bottle.

Name of Medication: _____

Prescribed Dosage: _____

Time Schedule for Administration: _____

Discontinuation date: _____

Reason for Administration: _____

Possible Side Effects: _____

Allergies: _____

Additional directions: _____

Regarding asthma inhalers, the child (check only one) _____ is / _____ is not able to self-administer the medication. If the student can self-administer, she/he has permission to carry the inhaler.

Regarding epi-pens, the child (check only one) _____ is / _____ is not permitted to carry the epi-pen with them.

I do hereby release, discharge and hold harmless the Carlynton School District, its agents and employees, from any and all liability and claims whatsoever arising from the administration of the above medication to my child/ward which I hereby expressly authorize.

_____ _____

Licensed Prescriber Name Printed Licensed Prescriber Signature

_____ _____

Parent/Guardian Name Printed Parent/Guardian Signature

_____

Phone Number of Parent/Guardian

In accordance with school district policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, each student MUST provide the school nurse with a School Medication Authorization form signed by the student's licensed prescriber and the student's parent/guardian.