

Maize USD 266

AUTHORIZATION FOR MEDICATION / TREATMENT TO BE ADMINISTERED AT SCHOOL

Name of Student: _____ DOB: _____

School: _____ Grade/Teacher: _____

HEALTHCARE PROVIDER MEDICATION / TREATMENT ORDERS

Medication Name: _____

Prescribed or Recommended Dosage: _____

Time / Frequency of Administration: _____

Length of Time of Prescription: _____

Additional Instructions or Notes: _____

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Has permission to carry and self-administer prescription medications for diabetes, asthma, or anaphylaxis per doctor's orders

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Has demonstrated the skill level necessary to use the medication and/or device necessary to administer the medication

Healthcare Provider Signature

Healthcare Provider Name (print)

Date

I grant permission for the school nurse or a delegated staff member to administer, or aid in the administration of medication/treatment to my child at school as indicated by my child's health care provider. I hereby certify that the student identified above has previously had a least one dose of the prescribed medication listed below and did not have an adverse reaction from it. **Prescribed medication requires a health care provider order.** I also give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question.

I have read the Medication Policy of Maize USD 266. I understand that I must provide all medication in its original labeled container. If self-administration of medication is needed, I understand that it is my responsibility to furnish the medication in the original container. I acknowledge that the school district and its officers, employees or agents incur no liability for damage, injury or death resulting directly or indirectly from the self-administration of medication and indemnify and hold the school and its officers, employees and agents, harmless from and against any claims relating to the self-administration of such medication. I confirm that my child has been instructed on the proper use of this medication and is able to self-administer this medication on his/her own without school personnel supervision. The student understands the expected response to the medication and what side effects and adverse responses should be reported to an adult. I acknowledge receipt of and/or have provided a written treatment plan prepared by a health care provider for managing asthma, anaphylaxis episodes, or for a chronic health condition.

Parent Signature

Date

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Has demonstrated the skill level necessary to use the medication and/or device necessary to administer the medication

School Nurse Signature

Date