

**PAW PAW CUSD #271
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FORM**

TO: PARENT OR GUARDIAN

Our district policy states that all prescription and non-prescription medications that are given during school hours must have this form completed prior to the administration of any medication. Medications prescribed daily, twice or three times daily should be administered under the guidance of the parent around school hours. No medication will be given during the school day unless absolutely necessary for the critical health and well-being of the student.

All medication sent to school must be:

- 1) In the original prescription bottle or for non-prescription medication in the original manufacturer's package.
- 2) Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route, and the time to be given, name of pharmacy; and
- 3) Medication should be brought to school by the parent/guardian or other responsible adult.

This medication form must be completed with the medication packaged properly as outlined above or the **medication will not be given**. Please complete this form and return it to the school nurse. This information is kept confidential. Thank you for your cooperation.

INFORMATION OBTAINED FROM PHYSICIAN:

Student Name: _____ Birthdate: _____

Name of Medication and Dosage: _____

Route and Time: _____

Possible Side Effects: _____

Diagnosis/Reason for Medication: _____

Other Medications: _____

Approval for Self-Administration

(Field trips or medication required at time when nurse is not in the building)
Self-administration will be under the supervision of voluntary school personnel.

_____ Indicate yes or no

Approval for student to carry and use emergency medication

(Inhaler/Epi-pen) (Recommend age 10 years and over, only)

_____ Indicate yes or no

Approval for Blood Glucose Management

Patient's insulin schedule and diabetes control may be modified by parent's authorization

_____ Indicate yes or no

Physician's Signature

Date

Physician's Name – Please Print

Phone Number/Fax Number

PARENT AUTHORIZATION AND SIGNATURE:

I authorize Paw Paw Public Schools and its employees, on my behalf and stead, to administer or attempt to administer (or to allow my child to self-administer while under the supervision of the employees and agents of this school district) to my child this lawfully prescribed medication and any prescribed changes. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school district, its employees, and agents arising out of the administration of said medication. In addition, I agree to release, hold harmless, and indemnify the District and its employees from any and all claims, damages, causes of action or injury incurred or resulting from the administration or attempts at administration of said medication. I allow the school nurse to discuss this medication and its effects on my child with the prescribing physician or his representative.

Parent/Guardian Signature

Date

Daytime Phone Number

Emergency Phone Number