PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION OF MEDICATION TO STUDENTS

Dear Parents:
Section 507.2 of School Board Policy states: "If a student must take prescribed medication during school hours, written authorization and instruction must be provided by the parents or legal guardian of the student, as well as by a licensed physician or health practitioner. However, non-prescription drugs may be administered by non-licensed, designated school personnel upon written request and instructions of the student's parent or legal guardian. "

Prescription Medication: In order to help us implement this policy, all prescription medication must be brought to school in the labeled prescription container from the pharmacy. All controlled medication will be counted and kept in a locked secured cabinet.

1. Name of student	**4. Name of physician prescribing medication**
2. Name of medication	**5. Time medication is to be given at school**
3. Dosage	**6. Route of administering medication (oral, eardrops, eye drops, and inhaler)**

Over the counter or non-prescription medication should be provided in original containers with the following information:

1. Name of student	**4. Time to be given at school**
2. Name of medication	**5. Route of administering medication**
3. Dosage	

The bottom part of this form must be completed and returned for your child to have medication administered during school. If more forms are needed, they will be available on the school website, at the school office, as well as at the local medical clinics and in-town doctor's offices. Please remind your doctor when he/she prescribes medication that you need this form completed. If you have any questions, please contact your school nurse.

School fax numbers: Stewart Elementary: 653-5313; Lincoln Elementary: 653-6800; Middle School: 653-7350; High School: 653-6751

_____ _____ / _____/_____
Students Name (Last), (First), (Middle) Birthday

_____ _____/_____/_____
School Date

_____ _____ _____ _____
Medication /Healthcare Dosage Route Time to be given

_____

_____ _____
Admin Instructions, Special Directives, Signs to Observe and Side Effect Length of time required to take medication

_____ _____ _____ ____ / ____/_____
Prescriber's Signature (if prescription medication) Address Physician Phone # Date

I request the above named student receive medication at school and school activities, according to the prescription, or other medication administration instructions, and a written record kept. The information is confidential except as provided by the Family Education Rights and Privacy Act (FERPA). I agree to coordinate and work with school personnel and prescriber (if any) when questions arise. I agree to provide a safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment. Procedures for medication disposal shall be in accordance with federal and state law.

_____ _____ _____ ____ / ____/____
Parent or Guardian Signature Address Parent Phone # Date