Rose Hill USD 394

AUTHORIZATION FOR MEDICATION / TREATMENT TO BE ADMINISTERED AT SCHOOL

Part A

Parent/Legal Guardian to Complete

Name of Student:________________________________ Date of Birth:_________ Grade/Teacher: ___________

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school as indicated by my child's health care provider or myself accordingly below. 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 Rose Hill USD 394. 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/Legal Guardian Signature Parent/Legal Guardian (Printed Name) Today's Date

Part B

Physician to Complete for Medications Listed Above

Parent to Complete for Over-the-Counter Medications

Current Diagnosis(es): ____

HEALTH CARE PROVIDER MEDICATION AND/OR TREATMENT ORDERS: (please specify)

Medication Name and Purpose: ____

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Prescribed or Recommended Dosage: ____

Time / Frequency of Administration: ____

Length of Time for which the Medication is Prescribed: ____

Additional Special Instructions or Circumstances: ____

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For grades K-12

☐ has permission to **carry** prescription medications for diabetes, asthma, anaphylaxis per doctor's instructions

☐ has permission to **self-administer** prescription medications for diabetes, asthma, anaphylaxis per doctor's instructions

For grades 9-12

☐ has permission to self-administer over the counter medication

___________________________ ___________________________ _______________

Health Care Provider Signature Health Care Provider (Printed Name) Today's Date

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Health Care Provider Phone Number