Rush City Public Schools
Independent School District #139

Authorization for Administration of Medication at School

Name of Student_____

Birth Date_____ School Year_____ Grade_____

Medical Condition	Medication	Strength Mg/mL	Dose	Time/ Freq.	Route	Start Date	Stop Date

NOTE: All authorizations expire at the end of the school year or at the end of extended year summer school.

_____

Print or type name of physician/licensed prescriber Signature of physician/licensed prescriber

_____ _____ _____ _____

Clinic Name/Address Fax Number Phone Number Date

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request that the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event any adverse reactions result from taking medication(s).
3. I will notify the school of any change in the medication(s) (e.g. dosage change, medication discontinued, etc.).
4. I give permission for the school nurse or designee to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
5. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
6. I give permission for the school nurse or designee to consult (in oral or written format) with the student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medication condition(s) being treated.

☐ My child may self-administer his/her inhaler/EpiPen if appropriate as assessed by the school nurse.

_____ _____

Parent/Guardian Signature Relationship to Student

_____ _____ _____

Home Phone Work/Cell Phone Date

Medication must be supplied in the original/prescription bottle.

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