AUTHORIZATION For Self-Administration of Medications

LINCOLN TRAIL DISTRICT HEALTH DEPARTMENT

HARDIN COUNTY SCHOOLS

Medications will be given at school only with written permission from the child's parent or guardian. Prescription medications must have the written permission from the Health Care Provider to administer. The medication must be in the original bottle with pharmacy label as proof of prescription. Signed permission will expire at end of the school year.

Student _____ Birth Date_____ Allergies_____

COMPLETED BY PHYSICIAN

I hereby attest that this child has been properly instructed and is competent to administer the following medication:

Name of Medication: _____
Medication Dosage: _____
Time of day for Dose: _____
Possible Reactions or Side Effects: _____
_____
_____

_____ _____ _____
Signature of Primary Care Provider Telephone Date

_____ _____
Printed Name of Primary Care Provider Address

COMPLETED BY PARENT

I hereby request that school personnel allow my child to self-administer the medication described below:

*Medication:*_____ *Dose:*_____ *Frequency:* _____

Prescribing Primary Care Provider: _____

Address: _____

Phone: _____

I hereby give permission for my child to receive the above medication at school according to school policy and expressly waive any liability on behalf of the school or health department as a result of administration of the above medication. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the request for medication to be followed. My signature will give permission for exchange of verbal and written communication between the Health Care Provider and the School Nurse regarding my child's medical regime. I hereby give my authorization and consent to trained school personnel to give prompt treatment, as specified above under Emergency Plan of Action to my child.

Parent or Guardian Signature _____Phone_____ Date_____

Emergency Contact _____Phone _____Relationship _____