Parental Consent and Licensed Prescriber Authorization
For Administering Medication
(Use a separate authorization form for each medication)

Parental Consent

Student's Last Name: _____ First Name: _____ M.I. ____

Teacher _____ Grade _____ Date of Birth: ____/____/____

Allergies: _____

Parental Consent

I am the parent or guardian of _____. I give permission for him/her to take the following prescribed medication while in _____ school. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medications. I hereby release Washington County Schools and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize the school nurse or principal designee to administer the medication and a representative of the school to share information regarding this medication with the licensed prescriber noted below.

_____ _____ _____
Parent/Guardian Signature Daytime Phone Date

***** *All medications must be furnished by the parent, in the* ***ORIGINAL*** *container, with the pharmacy label intact and delivered to the schools office. Students are prohibited from carrying medications on the school bus unless special permission has been obtained from the principal.*

Medication Authorization

(For Use By Licensed Prescriber ONLY)

Relevant Diagnosis _____ ICD-9 Code_____ Medication _____

Dates medication must be administered at school:
____ Short Term (List dates to be given): _____
____ Every Day at school
____ Episodic/Emergency Events ONLY

Dosage (Amount): _____ Route: _____ Time(s) of Day: _____

Serious reactions/adverse side effects from this medication may occur: _____ YES _____ NO

Action/Treatment for reactions: _____
Report to you: _____ YES _____ NO (Drug information sheet may be attached)

Asthmatic/Diabetic Authorization ONLY

This student is both capable and responsible for self-administering this medication:
____ NO ____ YES-Supervised ____ YES-Unsupervised

This student may carry this medication: ____ NO ____YES

Licensed Prescriber's Name: (Print)_____

Telephone Number _____ **Emergency Number** _____

Licensed Prescriber's Signature _____ **Date** _____

REV/09