

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION PERMIT  
MERIDIAN CUSD #223**

**TO: PARENT/GUARDIAN**

Our school policy states that all prescription and non-prescription medications that are given during school hours **must have this form completed prior to the administration of ANY medication.** No medication will be given unless absolutely necessary for the critical health and well being of the student. **All medication sent to school must be:**

1. ***In the original prescription bottle or, for non-prescription medication, in the original package.***
2. ***Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route and the time to be given, and the name of the pharmacy.***
3. ***This permit is valid for one school year only and must be renewed each year.***

**TO BE COMPLETED BY THE PHYSICIAN**

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_  
Name of Medication and Dosage \_\_\_\_\_  
Frequency \_\_\_\_\_ Time to be given at school \_\_\_\_\_  
Route of administration (ie: oral, injection) \_\_\_\_\_  
Diagnosis requiring medication \_\_\_\_\_  
Expected side effects, if any \_\_\_\_\_  
Other medications student is receiving \_\_\_\_\_

**Instructed in and approved for self-administration of emergency medication**

Student understands need for medication and the necessity to report to school personnel any unusual side effects or the failure of the medication to relieve symptoms. This student is capable of using this medication independently.

YES      NO  
DOES NOT APPLY  
(Circle one)

**Instructed in and approved for carrying/self –administration of other medication as designated above by Physician. (ie: Epi-pen, inhaler)**

YES      NO  
DOES NOT APPLY  
(Circle one)

\_\_\_\_\_  
Physician's Name (Please print)  
Office Phone Number \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature  
Date \_\_\_\_\_

**TO BE COMPLETED BY PARENT**

1. I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices, and
2. I indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct arising out of the self-administration of medication by the student.
3. If applicable, my child may possess and use his/her asthma medication (inhaler) while in school, while at school-sponsored activities, or while in before-school or after-school care on school operated property.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date