AUTHORIZATION FOR ADMINSTRATION 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 YES NO

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. 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) Physician's Signature
Office Phone Number_____ 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