MIDLAND COMMUNITY SCHOOL DISTRICT

Authorization and Permission for Medication Administration

Today's date: _____ Student's birth date: _____

Student's name: _____ Student's grade: _____

In accordance with the policy of the Midland Community School District, if it becomes necessary to administer medication to a student at school, the following guidelines must be met:

- Written authorization and instruction is provided by a parent or legal guardian
- A physician signature is required for any prescription medication and over the counter medication to be given more than 5 consecutive days.
- Medication is labeled and in its original container as dispensed or the manufacturer's labeled container
- The prescription label must contain: Name of Medication, Prescribed Strength and Dosage, Name and Address of Pharmacy, Student's Name, Physician's Name, Date of Prescription. This information must be on a **current** label from the pharmacy.
- If administration directions (medication dose, time, etc.) are changed, the parent must complete a new signed statement indicating the change. A change of orders may be verified and accepted by telephone only by the school nurse.

This form is available from the school office and also on the Midland Community School website.
This form must be completed and returned to the school office before any prescription of long term medication will be given to your child.

Medication name & strength: _____

Dosage to be given each time: _____

What time dosage is given at HOME: _____

What time dosage to be given at SCHOOL: _____

What are the side effects? _____

The above medication is to be given until: _____

Physician/Clinic Name: _____

Physician /Clinic Address & Phone #:_____

CONFIDENTIAL HEALTH INFORMATION RELEASE

I give my permission to the school nurse or designated staff to administer the above medication and share information relevant to my child's health condition relating to the administration of this medication with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information regarding this medication with my child's primary care physician for the purpose of referral, diagnosis, and treatment. Your signature also authorizes us to share this information with appropriate school personnel and Grant Wood Area Education Agency staff.

Parent Signature _____

Parent daytime phone number _____Date: _____

……

Prescribing Physician Name (printed):_____

Prescribing Physician's Signature_____