

UNIFIED SCHOOL DISTRICT 354

PERMISSION FOR MEDICATION ADMINISTRATION AT SCHOOL

Name of Student _____ Grade _____

Medication _____ Dosage _____

Date Medication Started _____ Time of day medication is to be given _____

For **inhaled** medications, please check one of the following:

_____ I have instructed the above named student in the proper way to use his/her medication. It is my professional opinion that this student should be allowed to carry the above prescribed medication and self-administer as prescribed.

_____ It is my professional opinion that the above named student should not be allowed to carry his/her medication by himself/herself.

Comments/Special Instructions: _____

Signature of Physician Date

- I hereby give my permission for _____ to take the above prescription at school as ordered.
- I certify that the child named has received at least one dose of the medication requested and has not had adverse reactions to it.
- I understand that any school employee who administers the drug to my child in accordance with written instruction from the physician or dentist shall not be liable for damages as a result of an adverse reaction to the drug.
- I understand that it is my responsibility to furnish this medication.
- I agree to the procedures lined in the Guidelines for Prescription and Nonprescription Drugs.
- I authorize appropriate USD 354 personnel to exchange information regarding this medication request with the health care provider listed and with the dispensing pharmacy identified on the medication label.

Signature of Parent or Guardian Date

NOTE: The medication is to be brought to school in the original container appropriately labeled by the pharmacy or physician, stating the name of the medication, the dosage, and times to be administered.