

MASON CONSOLIDATED SCHOOLS

Medication Prescriber/Parent Authorization Form Including Self-Administration/Self-Possession

Student name: _____ Birth date: _____ Teacher: _____ Grade: _____ School year: _____

To be completed by physician/licensed prescriber:

	Medication Name	Dose	Time to be Given	Form/Route*	Side Effects	Adverse Reaction
1.						
2.						

*Routes: Oral (pill/capsule/chewable, liquid); inhaled (inhaler, nebulizer); topical skin application; topical (eye drop, ointment); topical ear drop; injection; other (list)

Report side effects to my office immediately.

List minimal frequency between doses (especially if p.r.n): _____

If p.r.n. – list symptoms/conditions under which medication is to be given: _____

Reason for medication (*optional*): Medication #1: _____ Medication #2: _____

Special instructions (storage/sterility requirements/probable side effects): _____

Start date (if not beginning of school year): _____ Stop date (if not end of school year): _____

Physician's Signature

Date

Physician's Printed Name

Physician's phone number: _____ Fax number: _____ Address: _____

To be completed by parent/guardian:

I request and give permission for (name of child) _____ to receive the above medication(s)/treatment at school according to standard school district policy and for the physician('s)/staff and school district staff to share information needed to assist with my child's medication needs. I will assume responsibility for safe delivery of the medication to school (schools require parent/guardian to bring medication in its original container). I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian signature: _____ Date: _____

Home phone: _____ Work phone: _____

The following staff members (Peggy Parran, Paula Ridener, Brandon Bates, JoAnn Spicer) are authorized to administer the above-prescribed medication(s)/treatment(s).

Principal's signature: _____ Date: _____