Authorization/Permission for Administration of Prescription Medication for 2018-19 School Year

Dakota Valley Public Schools # 61-8

Student Name_____ Birth Date _____

Medications and health care procedures required during school. Which cannot be managed otherwise shall be administered **when the following are on file at the school:**

1. Physician's signed and dated authorization including the mediation/procedure, reason for receiving, dosage, route of administration, and time given at school.
2. Parent signed, dated authorization/permission given to administer the medication/procedure
3. Medication/equipment must be delivered to school **by the parent** in the **original packaging.**
4. **Annual renewal** of authorization/permission and/or immediate notification, **in writing from the physician**, of changes (when applicable).
5. Medication/procedure shall be administered by qualified staff and a record maintained.
6. Medication/equipment will be stored in a secure area.

The above named student is under my medical supervision. I have prescribed the following:

_____

Medication/Procedure | Dosage | Route

_____

Time given at school | Discontinue date/re-eval date

_____

Reason for medication/procedure

_____

Anticipated reaction/possible side effects

_____ _____

Physician Signature | Date

_____ _____

Physicians address | Physician's phone

Parent Authorization/Permission

I request the above pupil be given the medication/procedure while in school and school related activities. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication/procedure where the person administering the medication/procedure acts as an ordinarily reasonable, prudent person would under the same similar circumstances. I agree to pick up remaining medication or it will be properly destroyed.

_____ _____

Parent Signature | Date

_____

Parent Address | Work Phone | Home Phone | Cell Phone

Adopted: April 10, 2006