**MEDICATION AUTHORIZATION FORM**

**PARENT/GUARDIAN SECTION**

This section ***must*** be completed and signed for **ANY** medication (over the counter **or** prescription) to be kept at school for student use during school hours. All medications and products shall be locked in the school office unless there is a need for student to carry and self-administer the medication (see “special request” section below). This form is valid for the duration of the \_\_\_\_\_\_\_\_\_ school year, unless otherwise indicated.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Student Name:** | | **Date of Birth:** | **Age:** | **Grade:** |
| **Allergies:** | | | | |
| **Medication name and strength:** |  | | | |
| **Dose/frequency directions:** |  | | | |

*I hereby release the Gillett School District Board of Education and its agents and employees from any and all liability which may result from my child taking the medication identified on this form. Furthermore, I give permission for the School Nurse (or delegate) to contact the health care provider named below if any questions arise regarding administration of this medication.*

*I will supply the medication listed on this form for my son/daughter’s use during school hours, and will be responsible for picking up the product a) at the end of the school year, b) when the medication expires, and/or c) when this authorization expires, whichever is earlier. I will be responsible to inform school staff if this medication is discontinued, or if there is a change in dosing instructions. I acknowledge it is my responsibility to inform school staff if my son/daughter has already received a dose of medication prior to the start of the school day.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

Parent/Guardian name (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**SPECIAL REQUEST FOR**

**SELF ADMINISTRATION OF MEDICATION**

*(Generally reserved for* ***emergency/rescue*** *medications only.)*

*(****NOT*** *for routine or OTC medications.)*

Special authorization is required for a student to carry and self-administer any medication in school. *All* requests are subject to approval by the health care provider listed on this form, as well as school district administration. Please contact school administration or the school nurse with any questions/concerns.

I hereby request the school to **allow my son/daughter to carry and self-administer the medication listed on this form.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

*SEE PAGE 2 (OVER) FOR HEALTH CARE PROVIDER AUTHORIZATION →*

|  |  |
| --- | --- |
| **GILLETT SCHOOL DISTRICT** | **Elementary Phone: 920-855-2119| Fax: 920-855-1502** |
| **RETURN FORM TO SCHOOL OFFICE** | **Secondary Phone: 920-855-2137| Fax: 920-855-6600** |

**MEDICATION AUTHORIZATION FORM**

**PROVIDER SECTION**

This section ***must*** be completed and signed in order for

1) **ANY** prescription medication to be kept at school and administered during school hours

2)**ANY** request received for student to ***independently carry and self-administer*** medication (RX or OTC) during school hours; each request is subject to approval by school district administration.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(insert patient name &DOB)* is under my care. I agree to provide guidance regarding the medication noted on this form, and further agree it is appropriate for the district to store and aid in administration of said medication, as follows:

|  |  |
| --- | --- |
| **Medication Name/Strength** |  |
| **Administration Instructions** | **Dose: Route: Frequency: Duration:** |
| **Indication or Diagnosis:** |  |
| **Add'l info - possible reaction or effects** |  |

|  |  |  |
| --- | --- | --- |
| **SELF ADMINISTRATION AUTHORIZATION**  (Complete only if parent/guardian requests - see page 1)  The patient noted herein is deemed appropriate to carry and self-administer the medication listed on this form, please allow student to do so if:  1) Requested by his/her parent/guardian -***and-***  2) Approved by school district administration | **YES**  (patient **IS** appropriate)  ***Initials:*** | **NO**  (patient is **NOT** appropriate)  ***Initials:*** |

|  |  |
| --- | --- |
| Health Care Provider's Signature:  Date: | Clinic Address: |
| Health Care Provider's Name (*print*): | Clinic Phone: |
|  | Clinic Fax: |

*SEE PAGE 1 (OVER) FOR PARENT/GUARDIAN AUTHORIZATION OR REQUEST →*

|  |  |
| --- | --- |
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