

Maize USD 266

AUTHORIZATION FOR MEDICATION / TREATMENT TO BE ADMINISTERED AT SCHOOL

Part A

Parent/Legal Guardian to Complete

Name of Student: _____ Date of Birth: _____ Grade/Teacher: _____

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school as indicated by my child's health care provider or myself accordingly below. I hereby certify that the student identified above has previously had a least one dose of the prescribed medication listed below and did not have an adverse reaction from it. **Prescribed medication requires a health care provider order.** I also give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question.

I have read the Medication Policy of Maize USD 266. I understand that I must provide all medication in its original labeled container. If self-administration of medication is needed, I understand that it is my responsibility to furnish the medication in the original container. I acknowledge that the school district and its officers, employees or agents incur no liability for damage, injury or death resulting directly or indirectly from the self-administration of medication and indemnify and hold the school and its officers, employees and agents, harmless from and against any claims relating to the self-administration of such medication. I confirm that my child has been instructed on the proper use of this medication and is able to self-administer this medication on his/her own without school personnel supervision. The student understands the expected response to the medication and what side effects and adverse responses should be reported to an adult. I acknowledge receipt of and/or have provided a written treatment plan prepared by a health care provider for managing asthma, anaphylaxis episodes, or for a chronic health condition.

Parent/Legal Guardian Signature

Parent/Legal Guardian (Printed Name)

Today's Date

Part B

Physician to Complete for Medications Listed Above Parent to Complete for Over-the-Counter Medications

Current Diagnosis(es): _____

HEALTH CARE PROVIDER MEDICATION AND/OR TREATMENT ORDERS: (please specify)

Medication Name and Purpose: _____

Prescribed or Recommended Dosage: _____

Time / Frequency of Administration: _____

Length of Time for which the Medication is Prescribed: _____

Additional Special Instructions or Circumstances: _____

For grades K-12

- has permission to **carry** prescription medications for diabetes, asthma, anaphylaxis per doctor's instructions
- has permission to **self-administer** prescription medications for diabetes, asthma, anaphylaxis per doctor's instructions

For grades 9-12

- has permission to self-administer over the counter medication

Health Care Provider Signature

Health Care Provider (Printed Name)

Today's Date

Health Care Provider Phone Number