MEDICATION: *Authorization/Request for Medication Administration in School*	JGCD-1	11/01/2005 Revised : May 2013

Please Note: This medication consent is effective for one school year and must be renewed annually.
(To be completed by Health Care Provider)

NAME OF STUDENT: ________________________________ DOB: _______________ SCHOOL: _____________________________

MEDICATION: ______________________________________ DOSAGE: ____

TIME MEDICATION IS TO BE GIVEN: ____

TO BE GIVEN FROM (DATE) ______________________________________ TO ____

Significant Information: (include side effects, toxic reactions, omission reaction, contraindications):

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

1. Contact me at my office ____
2. Take the child to the ER at ____
3. Other options: ____

EMERGENCY MEDICATIONS: Please complete this box for emergency medications only!!

___ **Yes** ___ **No** ___ **N/A** Student may possess and self administer **ASTHMA** medications during the school day, at school sponsored activities, on the bus, or on other school property.

___ **Yes** ___ **No** ___ **N/A** Student may possess and self-administer an **EPI-PEN AUTO INJECTOR** during the school day, at School sponsored activities, on the bus, or on other school property.

___ **Yes** ___ **No** The student understands or has been instructed on self-administration of their emergency medication and Has demonstrated the skill level necessary to use the medication and any device necessary to administer the medication.

Physician's Signature: ____

Physician's phone: ____

DEA # ____ **Date:**__________

Office Stamp:
(please)

To be Completed by the Parent/Guardian:

I understand that the medicine prescribed will be provided to the school in the original pharmacy labeled container with appropriate identifying information (name of child, medication dispensed, dosage prescribed, and the time it is to be given). If this is an over-the-counter product, the medication will be provided in the original container. I understand the medicine will be delivered to school personnel by a parent/guardian and that ***students are not to transport medications.*** *I hereby give permission for school staff (trained in medication administration) to administer the above named medication to my child according to the healthcare provider's directions. I hereby release the LEA and all its agents and employees from any and all liability that may result from my child taking a prescribed medication or for injuries arising from a student's possession or self-administration.*

Parent/Guardian Signature: ________________________________ **Phone:** __________________ **Date:** ____________

School Nurse Signature: ____ **Date:** ________________________

Principal Signature: ____ **Date:** ________________________