KANE AREA SCHOOL DISTRICT
POLICY 210.1 AUTHORIZATION FORM
KANE, PENNSYLVANIA 16735

Authorization For Medication During School Hours for the 2024-2025 School Year

Dear Parent or Guardian:

It is a procedure of the Kane Area School District to administer prescribed medication during school hours only when absolutely necessary.

To protect your child and the other students, this permission information form must be completed and returned to school if your child must receive prescribed medication during the school day.

Medication must be sent to school in a container with the prescription labeled by a pharmacist or a physician, including the information requested below. Please do not send unlabeled bottles to school.

Any change in type or dosage of medication must be prescribed by the doctor, in writing. If the medication is stopped, this also must be reported in writing.

Aimee Kemick, RN and Amy Boults, RN

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TO BE COMPLETED BY PHYSICIAN

NAME OF STUDENT_____

MEDICATION_____

REASON FOR MEDICATION_____

DOSAGE/TIME OF ADMINISTRATION_____

DURATION OF PRESCRIPTION_____

POSSIBLE SIDE EFFECTS/CONTRAINDITIONS_____

LIST ANY SCHOOL ACTIVITIES WHICH SHOULD BE CURTAILED_____

Is this child authorized to carry and self-medicate with asthma and/or anaphylaxis medication? Yes No N/A

I have trained this student in the proper administration and frequency of use- Yes No N/A

DATE_____PHYSICIAN'S SIGNATURE_____PHONE_____

To the school: Please report concerns about medications or disease to the above physician.

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TO BE COMPLETED BY PARENT/GUARDIAN

This will confirm that I desire my child (ward) to receive medication during school hours, as stated above. **I as the parent/ guardian acknowledge that the school bears no responsibility in ensuring that the self-administered medication is taken.** Intending to be legally bound hereby, I do release, discharge and agree to indemnity and hold harmless the Kane Area School District, its agents and employees from any and all liability, loss and claim of whatsoever nature resulting from the administration of the above medication to my child and from any benefits or consequences from the prescribed medication. **Any violations in the medication policy by a student shall result in immediate confiscation of the asthma inhaler and medication and loss of privileges. School personnel may share observations with the doctor, and the doctor may be contacted to give information to personnel.**

DATE_____PARENT SIGNATURE_____

I will not allow other students to have access to this medication and I understand the appropriate safeguards and usage of this medication.

Date_____STUDENT SIGNATURE_____

The student has demonstrated that he/she is capable of self-administration of the asthma inhaler and/or epinephrine auto-injector in the school setting.

Date _____SCHOOL NURSE SIGNATURE_____

Revised 08/09/18