STEWARTVILLE PUBLIC SCHOOL AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Must be renewed annually

STUDENT NAME:_____ Birthdate: _____ GRADE:_____

I hereby request and authorize you to administer to the above-named student:

	Medication:	Dosage: (mg, ml, ect)	Route: (oral,topical, ect)	Time:	Duration:
1.					
2.					
3.					

Diagnosis/medical reason for medication:

Other medications the student is taking:

Allergies:

Other recommendations/**unusual** side effects:

PHYSICIAN'S SIGNATURE REQUIRED for all prescription medications and over-the-counter medications that exceed package recommendations or contain aspirin.
Parent signature only for over-the-counter medications kept at school and OTC self-carry.

PHYSICIAN'S SIGNATURE: **DATE SIGNED:**	I believe that the above named student is capable of self-carrying/self-administering the medication listed above.
X / /	□ Yes □ No
Print physician's name:	

Clinic Name:	Clinic Phone No.:	Clinic Fax No.:

PARENT/GUARDIAN AUTHORIZATION FOR *STAFF* ADMINISTRATION:

1. I request that the above medication be given during school hours.
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. I will notify the school of any change in the medication or licensed practitioner's order, dosage change, frequency, or duration of administration.
4. I give permission for Health Services Staff to communicate with teachers about the action and side effects of this medication as needed.
5. I give permission for Health Services Staff to consult with the above-named student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication if needed.
6. Field trips – I give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.
7. I understand that it is my responsibility to pick up any leftover medication at the end of the current school year or it will be disposed of.

Signature of parent/guardian: X _____ **Date Signed:** ____/_____/_____

Phone Numbers: Home _____Work_____ Cell _____

For Self-Administration and Self-Carry of Medications only, complete side 2

Self-administration is allowed for inhalers, Epi-pens, acetaminophen and NSAIDS (e.g. ibuprofen) **for 6-12th grade students only**. Other requests for self-administration will be handled on a case by case basis with the school nurse.

PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION and SELF-CARRY OF MEDICATION	
1. I give permission for my student to self-carry and self-administer the above-named medication(s) during school hours. I have read the student agreement below. 2. I have read and understood the district medication policy 516. 3. I understand my student will carry this medication at school. I also understand my student is entirely responsible for the use of this medication and the use of this medication will not be monitored by school personnel.	
Signature of Parent/Guardian:	**Date:**

SELF-ADMINISTRATION and SELF-CARRY OF MEDICATION – STUDENT AGREEMENT			
□ Inhaler	□ Over-the-Counter Pain Medication	□ EpiPen	□ Other (contact nurse first)
I agree to:			
1. Follow my prescribing health professional's medication orders.			
2. Use correct medication administration techniques.			
3. Not allow anyone else to use my medication.			
4. Keep a supply of my medication with me in school and on field trips.			
5. Notify the school nurse or health office personnel if the following occurs: ● My symptoms continue or get worse after taking the medication. ● My symptoms reoccur within 2-3 hours after taking the medication. ● I suspect that I am experiencing side effects from my medication. ● If I have any symptoms of an allergic reaction.			
6. I understand that if I am a **secondary student (6-12th grader)** and I am self-administering over-the-counter pain medication (Acetaminophen or non-steroidal anti-inflammatory e.g. ibuprofen), I have agreed to bring the original container with only the amount of medication that would be recommended in a 24 hour period. □ Yes □ NA			
7. I understand that permission for self-administration of medication may be suspended if I am unable to maintain the procedural safeguards established in this agreement.			
Signature of Student:			**Date:**

TO BE COMPLETED BY THE HEALTH SERVICES STAFF ONLY			
The student has demonstrated knowledge about and proper use of his/her (check one)			
□ Inhaler	□ Over-the-Counter Pain Medication	□ EpiPen	□Other
Health Services Staff Signature:			**Date**