

**Parental Consent and Licensed Prescriber Authorization  
For Administering Medication**

(Use a separate authorization form for each medication.)

<b>Parental Consent</b>		
Student's Last Name: _____	First Name: _____	M.I. _____
Student Number _____	Grade _____	Date of Birth: _____
Allergies: _____		
<b>Parental Consent</b>		
I am the parent or guardian of _____ . I give my permission for him/her to take the following prescribed medication while in _____ School. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medications. I hereby release _____ School and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the above licensed prescriber.		
Parent/Guardian Signature _____	Daytime Phone _____	Date _____

<b>Medication Authorization</b>	
(For Use By Licensed Prescriber <u>ONLY</u> )	
Relevant Diagnosis _____	Medication _____
Dates medication must be administered at school:	
_____ Short Term (List dates to be given): _____	
_____ Every Day at school	
_____ Episodic/Emergency Events ONLY	
Dosage (Amount): _____ Route: _____ Form: _____ Time(s) of Day: _____	
A. Serious reactions can occur if the medication is not given as prescribed: _____ YES _____ NO	
If yes, describe: _____	
B. Serious reactions/adverse side effects from this medication may occur: _____ YES _____ NO	
Action/Treatment for reactions: _____	
Report to you: _____ YES _____ NO (Drug information sheet may be attached.)	
Special Handling Instructions: _____ Refrigeration ___ Keep out of sunlight ___ Other _____	
<b>Asthmatic/Diabetic ONLY</b>	
This student is both capable and responsible for self-administering this medication:	
_____ NO _____ YES-Supervised _____ YES—Unsupervised	
This student may carry this medication: _____ NO _____ YES	
Licensed Prescriber's Name _____	
Telephone Number _____ Emergency Number _____	
Licensed Prescriber's Signature _____	Date _____