

(Use a separate authorization form for each medication)

Parental Consent

Student's Last Name: _____ First Name: _____ M.I. _____

Teacher _____ Grade _____ Date of Birth: ____/____/____

Allergies: _____

Parental Consent

I am the parent or guardian of _____. I give 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 Washington County Schools 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 licensed prescriber.

Parent/Guardian Signature Daytime Phone Date

** All medications must be furnished by the parent, in the **ORIGINAL** container, with the pharmacy label intact and delivered to the schools office. Students are prohibited from carrying medications on the school bus unless special permission has been obtained from the principal.*

Medication Authorization

(For Use By Licensed Prescriber ONLY)

Medication _____

Relevant Diagnosis _____ ICD-10 _____ (required)

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: _____ Time(s) of Day: _____

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)

Asthmatic/Diabetic ONLY

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: (Print) _____

Telephone Number _____ **Emergency Number** _____

Licensed Prescriber's Signature

Date