DELL RAPIDS PUBLIC SCHOOLS #49-3
School Health Services
Request and Authorization for Medication or Physician-Prescribed Service

Name of Student______________________________________Grade___________Birthdate_______________________________

Parent/Guardian Name____________________________________ Phone Number_______________________________________

Physician/Licensed Health Care Provider______________________________ Phone __________________Fax _________________

Medicaid?_________________ If yes, please provide Medicaid number.____

We encourage medication administration/physician-prescribed services to be arranged outside of school hours, whenever possible.

PHYSICIAN/LICENSED HEALTH CARE PROVIDER AUTHORIZATION:

1. Diagnosis____
2. Medication/Physician-Prescribed Service____
3. Dose____
4. Time____
5. Method of administration____
6. Authorization Start Date____
7. Authorization End Date____
8. Precautions and reactions to observe and report____

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Signature of Physician/Licensed Health Care Provider (Required for Option I) Phone Date

REQUIRES RENEWAL AT BEGINNING
OF EACH SCHOOL YEAR

PARENT/GUARDIAN AUTHORIZATION:

OPTION I (School-Administered Medication/Physician-Prescribed Service):

1. I am the parent/guardian of _______________________________, and I authorize said child/ward to be administered the prescription/non-prescription (over-the-counter, OTC) medication or physician-prescribed service identified above while on school property or at a school-related activity/event by the school nurse or school employee trained in the administration of prescription medication or said physician-prescribed service.
2. I hereby release the school district and its employees/agents from liability for injury arising from the school's administration of the medication or physician-prescribed service while on school property or at a school-related activity/event.
3. I understand that if the student identified herein uses the medication in a manner other than prescribed, the student may be subject to disciplinary action by the school, however, any disciplinary action may not limit or restrict the student's immediate access to the medication.
4. I authorize the school to inform appropriate school employees who would have a need to know of the administration of medication (i.e., school nurse, teachers, teaching assistants, school administrators, activity supervisors, coaches, bus drivers).
5. I acknowledge and agree that the school shall secure (store) the medication for the student until administration of the medication is necessary, and that in no circumstances shall the medication be stored in the student's locker/desk.
6. I understand the medication must be provided in a pharmacy-labeled bottle identifying the name and telephone number of the pharmacy, the student's name, physician's name and dosage of the drug to be taken, and the time it is to be taken. An OTC medication must be provided in its original brand-name bottle with labels intact.
7. I understand that all medication not picked up by the last day of school will be destroyed unless prior arrangements have been made by contacting the school nurse, building secretary, or principal.

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Signature of Parent/Guardian Date

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Signature of School Nurse Date