MT. EPHRAIM PUBLIC SCHOOLS
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY THE SCHOOL NURSE

The following is to be completed by the Parent/Guardian:

School:_________________________________

Student's Name:____ Grade:__________ Birth Date:________

Last First MI

I request that my child be assisted by the school nurse in taking medication(s) as prescribed below by my child's healthcare provider. I will indemnify and hold blameless the District and any and all employees of the District against any injury or claims that arise as a result of the nurse's administration of my child's medication. I agree that the medication must be brought to school by a parent or guardian, and that the medication must be in it's original container, properly labeled from the pharmacy/manufacturer. I understand that I must renew this authorization annually. I give the school nurse permission to contact the healthcare provider below in regards to matters concerning my child's medication or condition.

____

Date **Parent/Guardian Signature** **Home Phone #** **Work/ Emergency #**

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THE FOLLOWING IS TO BE COMPLETED BY THE HEALTHCARE PROVIDER:
(Please fill out this section in it's entirety) ALL ASTHMA MEDICATIONS MUST HAVE AN ASTHMA ACTION PLAN

Child's Name:____ Child's Diagnosis:______________________________

Medication:____ Dosage:___________________ Route:________________

Frequency or time of da to be given at school:____

If medication is to be given *as needed*, please describe conditions:____

____

Please list any significant side effects:____

Length of time this treatment is to continue (no longer than one school year)____

Known allergies/other information:____

This medication may be omitted on half days and field trips: _________YES ___________NO

(Efforts will be made to employ a substitute nurse to accompany the class when students with health/medication needs are in attendance. The District cannot always guarantee the availability of a substitute nurse. A parent or guardian may accompany the student on a field trip for the purpose of administering medication).

It is my understanding that the school nurses/substitute school nurses of Mt. Ephraim School District charged with the administration of medication may rely upon my directions as contained in this document. I further certify that I am the healthcare provider who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alterations from the above will occur only with written directions from the attending healthcare provider.

_____ _____
_____

Date Healthcare Provider's Name (Please Print) Healthcare Provider's Signature

_____
_____

Address Phone Number