STUDENT MEDICAL AUTHORIZATION FORM

(Required when a student needs to take prescription and non-prescription medication at school.)

**Student Name:** ___________________ __________ **Birth Date:** __________________**School Year:** _____________

**School:** BUSHNELL-PRAIRIE CITY HIGH SCHOOL

School medications and health care services are administered following these guidelines:

- Physician/prescriber signed and dated authorization to administer the medication
- Parent/guardian signed and dated authorization to administer the medication
- The medication must in the original labeled container as dispensed or the manufacturer's labeled container
- The medication label must contain the student's name, name of the medication and directions for use and date
- Annual renewal of authorization and immediate notification of changes is required**Physician Authorization:**

____________________________________________/__________________________/______________________________
Medication/Treatment Dosage Time to be Administered

_____________________________________________________________________/_________________________________
Intended Effect of Medication/Treatment Side Effects (if any)

_____________________________________________________________________________________________________
Other Medication the Student is Taking

May the student self-administer the medication under the supervision of a school nurse or school designee?
________YES _______NO

Administration Instructions:
_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

Date to Discontinue, Reevaluate or Follow Up: _________________________________________________________________

_________________________________________________________/____________________________________________
Physician's Signature Date Signed

_________________________________________________________/____________________________________________
Physician's Emergency Phone Number Physician's Address

**Parent Authorization:**
I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Bushnell-Prairie City CUSD 170 and its employees and agents, on my behalf and stead, to administer or attempt to administer to my child or to allow my child to self-administer while under the supervision of an employee or agent of the School District, lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and I specifically consent to such practices. I further acknowledge and agree that when lawfully prescribed medication is so administered or attempted to be administered, I waive any claims that I might have against the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

_________________________________________________________/____________________________________________
Parent's Signature Date Signed

_________________________________________________________/____________________________________________
Parent's Phone Number Parent's Emergency Phone Number