AUTHORIZATION FOR MEDICATION ADMINISTRATION

To be completed by parent/guardian:

Student's Name: _____ Grade: _____ Date: _____

Birth Date: _____ School: _____

Parent/Guardian Name(s):_____

Telephone: Home _____ Emergency Contact: _____

Parent/Guardian Work: _____ Parent/Guardian Work: _____

Physician: _____ Hospital: _____

When requested by a healthcare provider, during school hours, a nurse or designee may assist with medication administration to students, with the licensed professional nurse's guidance. The licensed professional nurse is the only staff member who is qualified to supervise the assistance of medication administration in the school. This form must be completed and signed by the school nurse and the parent or guardian.

For the safety of all students, it will be the responsibility of the parent/guardian to transport medication. Exceptions can be made in rare cases. All medication must be brought in a prescription labeled bottle or a manufacturer's labeled bottle with directions for use. The labels must include the following information: name of student, name of drug, directions concerning dosage, time of day to be taken, name of the prescribing healthcare provider, and date of prescription. It is recommended that you request the pharmacy fill your prescription in two (2) labeled containers so there is proper labeling at home as well as at school. A parent is encouraged to administer the first dose of medication, prior to the student attending school, to observe any potential signs of reaction.

By signing this release form, I authorize the school nurse or designee to administer prescription medication to my child/student according to the original label or healthcare provider's orders and to communicate and/or exchange information with the doctor as allowed by FERPA and HIPAA. The Boise School District cannot assume any liability for consequences, which arise as a result of following the manufacturer's label or healthcare provider's orders. Please sign and return to the school office.

_____	_____	_____
Parent's/Guardian Signature	Relationship	Date
_____	_____	_____
Principal (optional)	Nurse	Date

To be completed by nurse:

Name of Medication: _____

Dosage and directions: (Copy from Label) _____

_____

03/04
Revised 07/16
Reviewed 07/16