

KENT CITY SCHOOLS STUDENT MEDICATION AUTHORIZATION

I hereby give permission to the principal and/or designee to administer the following medication or procedure to my child, _____, Grade _____ during school hours.
(Name)

Name of medication/procedure _____

Description _____
[color, form (tablets, capsules, liquid, etc.)]

Dosage (amount to be administered) _____

Time(s) to be administered _____

To be administered from _____ to _____
(date) (date)

Possible adverse reactions to medications which should be reported to the physician _____

Special instructions, including storage or sterile requirements _____

It is required that a bottle with a **prescription label** for the medication be provided to the school.

Physician's Signature _____ Business Phone Number _____

Emergency Phone Number _____

Physician's Address _____

I also hereby agree to deliver the medication to the school, to notify the school if I change physicians, and to notify the school if the medication, the dosage, or the procedure is changed or is to be eliminated. In the event any of the above information changes, I understand it is my responsibility to inform the principal and/or designee and **to complete a new Student Medication Authorization** form. The authorization is to remain in effect until revoked through my written statement to the school.

I give my consent to the physician, school nurse or their designees to send and/or receive information related to my child's health, as they deem appropriate for the duration of this order as noted above.

I understand and agree that the principal or his/her agent(s) has no responsibility for the content of said medication, nor for the refilling of said prescription, nor for the safeguarding of said prescription, other than precautions normally taken with respect to school property. I further understand that school personnel are not legally obligated to administer medication to any child, and I agree to hold the school district and its employees free from any and all responsibility for the results of administering such medication.

Parent's Signature _____

Student's Address _____

Relationship to Student _____ Date _____
Month / Day / Year

Principal's Signature _____

Teacher's Name _____

Person(s) authorized to administer medication or procedure signature(s):
