

**Missouri Valley School District
Authorization and Permission for Administration of Medication**

_____/_____/_____
Student's Name Date of Birth School _____
Date

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

- Parent signed, dated authorization to administer the medication.
- The medication is in the original labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student name, name of the medication, directions for use and date.
- Annual renewal of authorization and immediate notification, in writing, of changes.

Medication/Health Care Dosage Route _____
Time at School

Administration instructions

Possible adverse Reactions or side effects

Discontinue/Re-Evaluate/Follow-up Date

Prescriber _____
Date

Prescriber's Address _____
Emergency Phone

I request the above student be given the medication at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

Physician and I agree that this student needs medication on field trips. Yes ___ No ___

Parent/Guardian Signature _____
Date

Address _____
Home phone

Additional Information _____
Business phone _____
Cell Phone

