USD #403 Otis-Bison

Permission for medication administration at school

Name of Student:____DOB:_____________Grade:_________

Medication:____Dosage:_________________

Date medication started:________Time of day medication is to be taken:__________________________

For ***inhaled*** medications, please check the following:

_______I have instructed the above named student in the proper way to use his/her medication. It is my professional opinion that this student should be allowed to carry the above-prescribed medication and self-administer as prescribed.

Comments or special instructions:____

Diagnosis:____________
Signature of Physician:____**Date:**_________

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- I hereby give permission for ______________________________to take the above prescription medication at school as ordered and/or take the above non-prescription medication as directed on medications original container.
- I certify that the child named has received at least one dose of the medication requested and has not had an adverse reaction to it.
- I understand that a school employee who administers the drug to my child in accordance with the written instruction from the physician, dentist and/or as directed on medications original label (if non-prescription) shall not be held liable for damages as a result of an adverse reaction to the drug.
- I understand that it is my responsibility to furnish this medication.
- **I understand that the medication must be in its original container with the appropriate label by physician & pharmacy (if prescription.) Over the counter containers must have original bottle with dosing instructions clearly visible and able to read.**
- I acknowledge that the school incurs no liability for any injury resulting from self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.
- I authorize appropriate USD #403 personnel to exchange information regarding this medication request with the health care provider listed and with the dispensing pharmacy identified on the medication label.

Signature of Parent or Guardian:

____**Date:**_________________