

Alcester-Hudson Community School #61-1

Authorization and Release for Medications

I hereby request and authorize officials at ALCESTER-HUDSON SCHOOL to supervise the below stated medication for:

Student's name _____

Date _____ Grade _____

As Prescribed by Dr. _____

Medication _____ Dosage _____ Time _____

Method: Oral _____ Topical _____ Inhalation _____

Reason Child Is Taking Medication _____

Precautions and Reactions to Observe and Report _____

I understand that the school district and individuals involved will not be held liable from any adverse effects of the medication.

I understand the medication shall be provided in a bottle showing the name and telephone number of the Pharmacy, the student's name, Physician's name and dosage of the drug to be taken.

Date

Parent/Guardian Signature

Date

Phone call from Parent/Guardian

Call received by: _____

Authorization for Asthma or Anaphylaxis
Self-Administered Medication
INHALERS & EPI-PENS ONLY
Physician/Licensed Health Care Provider Statement

The student, _____, has:

- Asthma
- Anaphylaxis
- Both Asthma and Anaphylaxis

and is capable of self-administering the following prescription medication:

Name and Purpose of Medication: _____

Prescribed Dosage of Medication: _____

Times/Circumstances to Administer: _____

Period of Prescription: _____

Signature of Physician/Licensed Health Care Provider

Date

Parental Authorization

1. I, , am the parent or guardian of , and I authorize my child/ward to self-administer the prescription medication identified below while on school property or at a school-related event or activity.
2. I hereby release the District and its employees and agents from liability for injury arising from the student's self-administration of the medication while on school property or at a school-related event unless in cases of wanton or willful misconduct.
3. I understand that if the student identified herein uses the medication in a manner other than prescribed, the student may be subject to disciplinary action by the school. However, any disciplinary action may not limit or restrict the student's immediate access to the medication.
4. I authorize the school nurse to inform appropriate school employees who would have a need to know of the administration of medication (i.e., instructors, teacher aides, school administrators, activity supervisors, bus drivers) that the student may self-administer medication.
5. I give permission for the student to have the prescription medication in their possession while on school property or at a school-related activity or event.

Signature of Parent/Guardian

Date

Telephone # _____