CARETAKER AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION TO STUDENT

The undersigned(s) is/are the caretaker(s), parent(s), guardian(s), or person(s) in charge of _____("the Student").

It is necessary that the Student receive _____ (medication), a physician-prescribed medication, during school intervals beginning on _____ (date) and continuing through _____ (date).

CHECK ONE (1) OF THE FOLLOWING BOXES

_____I hereby authorize Sterling Public Schools to allow the Student to administer the above-described medication to himself/herself without monitoring or supervision by school personnel.

_____I hereby request Sterling Public Schools, or its authorized representative, to administer the above-named medication to the Student, in accordance with the prescribing physician's instructions, and agree to:

1. Submit this request to the principal or school nurse.
2. Make certain the Physician's Request for the Administration of Prescription Medication by School Personnel is submitted to the principal or school nurse.
3. Make sure personally that the medication is received by the principal or school nurse and/or county nursing services administering it, in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
4. Make sure personally that the container in which the medication is in is marked with the medication name, dosage, interval dosage, and date after which no administration should be given.
5. Submit a REVISED STATEMENT signed by the physician prescribing the medication to the principal or school nurse IF ANY OF THE INFORMATION PROVIDED BY THE PHYSICIAN CHANGES.
6. Provide directions to the school personnel providing the medication.
7. Provide monitoring of the medication's effects, and assume full responsibility therefor.

I understand that unlicensed school personnel may be assigned to provide medication to the Student and hereby release the School District and the Board of Education of the School District and all employees, agents, and representatives of the School District from any liability concerning the providing or non-providing of the medication to the Student.

DATED this _____ day of _____, 20__.

_____	_____
Work Telephone Number	Name of Student
_____	_____
Home Telephone Number	Parent/Guardian
_____	_____
Alternate Number for Parent	Parent/Guardian

PROVISION OF MEDICATION TO STUDENT
PHYSICIAN'S REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

Date _____

_____ (Student's full name) is under my care and must take medication which I have prescribed during the school day.

Name of medication (as it appears on container in which the medication is stored) _____

_____

Dosage and time _____

Date provision of medication is to begin _____

Date after which the medication should not be provided _____

Possible adverse reactions to be reported to physician _____

_____

Special instructions for the provision and storage of the medication _____

_____

_____ _____

Print or Type Name of Physician Primary Phone Number

_____ _____

Signature of Physician Secondary Phone Number