

# Authorization for Medication Administration

Kearney R-1 School District

This is to request the district designee to administer the medication or treatment prescribed below. All medications, both prescription and over-the-counter, must be in the original containers with the student's name and instructions for administration on the label.

A PHYSICIAN'S SIGNATURE IS REQUIRED ON ALL PRESCRIPTION MEDICATIONS DISPENSED AT SCHOOL LONGER THAN 30 DAYS. ALL MEDICATIONS MUST BE DELIVERED TO THE SCHOOL BY A PARENT OR AN ADULT.

Name \_\_\_\_\_ DOB \_\_\_\_\_

Date \_\_\_\_\_ School \_\_\_\_\_ Age \_\_\_\_\_ HR/Teacher \_\_\_\_\_

## Medication/Prescription Information

Prescription medication       Over-the-Counter Medication Provided by Parent/Guardian

Name of Medication: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Form of Medication/Treatment:     Tablet/Capsule    Liquid    Inhaler    Injection    Nebulizer    Other: \_\_\_\_\_

Special Storage Requirements:  None    Refrigerate    Other: \_\_\_\_\_

Describe the schedule and dose to be given at school: \_\_\_\_\_

If "AS NEEDED," dose & how often (i.e. every 4 hrs) \_\_\_\_\_

► Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

(Required for prescription meds only)

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

- I understand that I may cancel this request and retrieve the medication from the school at any time. I understand the medication will be destroyed if not picked up within one week following the termination of the order or one week beyond the close of school.
- I give district employees permission to contact the student's physician directly to provide information on the student's condition or to clarify medication administration instructions.
- I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication/supplies needed for my child's condition, and will inform the school district immediately if any information provided on this form changes.

## STUDENTS IN GRADES 6-12 ONLY

Students in grades 6-12 are allowed to carry and self-administer Inhalers/Epi-Pens/Diabetic supplies, if a physician & parent determines it safe and appropriate. Diabetics must be granted authorization in writing from their physician and demonstrate competency of their pump/insulin injections. The Kearney R-1 School District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by a student.

- I give permission for my child to carry and self-administer inhaler.      Yes \_\_\_\_\_ No \_\_\_\_\_ Initials \_\_\_\_\_
- I give my child permission to take their inhaler home on the last day of school.      Yes \_\_\_\_\_ No \_\_\_\_\_ Initials \_\_\_\_\_
- I give permission for my child to carry and self-administer a prescribed Epi-Pen.      Yes \_\_\_\_\_ No \_\_\_\_\_ Initials \_\_\_\_\_

► Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_