



Spirit Lake Community School District Authorization and Permission for Administration of Medication

Last Name:

First Name:

Date of Birth:

Date:

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

- > Parent has signed and 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 the date.
- > Annual renewal of authorization and immediate notification in writing from the doctor initiating the changes.

Medication Name:

Dosage:

Route/Administration Method:

Time:

Administration Instructions:

Prescriber/Doctor's Name:

Prescriber/Doctor's Address:

Emergency Phone Number:

Date to Discontinue/Re-evaluate:

I request the above-named student be given the medication at school and/or 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 or it will be properly destroyed.

Parent Signature:

Date:

Parent Address:

Phone #1:

Additional Information:

Phone #2: