

School Medication Authorization Form

<p>This form is to be completed by the student's parent(s)/guardian(s). A new form must be completed every school year and will be maintained in the school nurse's office or the school's main office.</p>		
Name of Student		Birthdate
Teacher	Grade	Room
Home Address		
Primary Phone		Emergency Phone
<p>This section is to be completed by the student's physician, physician assistant, or advanced practice RN.</p>		
Physician's Name (Printed)		Physician's Signature
Office Address		
Office Phone		Emergency Phone
Medication Name		
Purpose of Medication		
Dosage		Frequency
Administration Time/Circumstances		
Prescription Date		Discontinuation Date
Diagnosis		
Side Effects		
Other Medications of Student		
<p>For parents/guardians to permit dispensation of the listed medication by a nurse:</p>		
I give permission for the nurse to dispense the listed medication as indicated.		
Signature		Date
<p>For parents/guardians of students who need to carry asthma medication or an EpiPen®:</p>		
I authorize the school and its employees and agents, to allow my child or ward to possess and use his/her asthma medication and/or epinephrine auto-injector: 1-while in school or at a school-sponsored activity, 2-while under the supervision of school personnel, or 3-before or after normal school/school-sponsored activities on school operated property.		
Signature		Date
<p>For parents/guardians to permit dispensation of the listed medication by school personnel in an emergency:</p>		
By signing below, I agree that I am primarily responsible for the administration of medication to my child. However, in the event that I am unable to do so or in the event of an emergency, I hereby authorize the school and its designees and agents, in my behalf, to administer or attempt to administer the listed and lawfully prescribed medication in the manner stated above or allow my child to self-administer, while under the supervision of the designees or agents of the school. I understand that it may be necessary for the administration of medication to my child to be performed by an individual other than the school nurse and specifically consent to such practices and I agree to indemnify and hold harmless the Diocese of Trenton, the school and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of the child's self-administration of medication.		
Signature		Date