
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

NSSEO Board Policy 7:270 states that medication may be administered to students at school only when the student's parent/guardian has submitted an *Authorization for Administration of Medication* form. This form must be completed by the student's physician and parent/guardian.

The parent/guardian or designated adult is responsible for ensuring that the medication arrives safely at school in a pharmacy-labeled container. Medication to be administered during the school day must be brought to the school by the student's parent/guardian or a designated adult. All medication (both prescription and non-prescription) is not to be sent to school with the student, and cannot be given to a bus driver or bus aide for delivery to school. On the rare occasion when a parent/guardian is unable to deliver medication to the school during regular business hours, the parent/guardian should contact the school office to make arrangements. All prescription medication must be in a pharmacy-labeled container. The label must include the student's name, physician, name of the medication, dosage, and time to be given. All non-prescription medication must be in the original package. The completed form must be returned to the school nurse before the medication can be administered.

TO BE COMPLETED BY THE DOCTOR:

Student's name: _____

School of Attendance Diagnosis: _____

Medication and dosage: _____

Time of administration: _____

Possible side effects: _____

Special instructions: _____

Other medications student is receiving: _____

I hereby authorize NSSEO and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or allow my child to self-administer pursuant to State law, while under the supervision of the employees and agents of NSSEO), lawfully prescribed medication in the manner described above. I agree to indemnify and hold harmless NSSEO and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication. I authorize the mutual exchange of information regarding my child between the school nurse and the physician listed below.

Physician's Signature

Parent/Guardian's Signature

Phone Number

Relationship

Date

Date