May-Port CG School District

Authorization to Administer Medication

Child:_____ Teacher:_____

Parents:_____Phone: (H)_____ (W)_____

Address:_____

Known allergies of student:_____

Medication – Name and Prescription Number:_____

Dose:_____ How Given (Route):_____

Time/Frequency:_____ Continue Until:_____

Special Instructions:_____

Possible Side Affects:_____

Possible Effects on Learning and Physical Functioning:_____

_____

Physician:_____ Phone:_____

Address:_____

- **Medication to be taken at school must be supplied by the parents, will be stored in the school office or the nurse's office, and will be dispensed by designated school personnel.**
- **NO MEDICATION IS DISPENSED WITHOUT PRIOR WRITTEN PARENTAL CONSENT.**
- **Medication must be clearly labeled with the child's name.**
- **The following medication/procedures may be dispensed in the classroom by the teacher or student: Inhalers, Cough Drops, Eye Drops, Diabetic Self-Test Kits**

Parent/Guardian Authorization

I request/consent that this medication be given to my child in the manner specified above. I give permission to school personnel to administer the medication. I understand that the administration of the medication may or may not be done by a nurse. I will notify the school immediately if my child's health status changes or there is a change or cancellation of this medication.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the School Board, the individual members thereof and any officials or employees involved in the administration of medications to the above named student from any claims or liability for injury or damages including, but not limited to, costs and reasonable attorney's fees, caused or claimed to be caused, or to result from the administration of the above described medications.

Parent/Guardian:_____ Date:_____

Signature