BALTIC SCHOOL DISTRICT 49-1

MEDICATION AND TREATMENT AUTHORIZATION FORM 2017-18

Please complete this form if the below named student must take medication during school hours and it **cannot** be given at home. Baltic School District requires *this form be completed by the parent for over-the-counter medications and both parent and physician for prescription drugs before administering any medication*. Medication must be delivered directly to the school Administrative office personnel by the Parent/Guardian or responsible adult in the original pharmacy or manufacturer's container**. For your child's safety and the safety of other children, students are not allowed to carry medication to/at school unless prior authorization has been given by the school. Renewal is required at the beginning of each school year.**

PRESCRIPTION MEDICATIONS – Part One - Must be completed by Parent/Guardian

Student's Name: _____ Date: _____

DOB: _____ Grade/Teacher: _____ Bus Yes ____ No ____

Parent/Guardian Name: _____

Home: _____ Wk: _____ Cell: _____ Email: _____

PRESCRIPTION MEDICATIONS – Part Two - Must be completed by Physician

1. Diagnosis: _____ Allergies: _____
2. Name of Medication/Treatment: _____
3. Dosage/Amount Prescribed: _____
4. Route (by mouth, eye drops, intranasal, etc.): _____
5. Time Given: _____
6. Frequency (daily, weekly, as needed, etc.): _____
7. Duration (beginning date and discontinue date): _____
8. Possible Side Effects:_____
9. Any Special Instructions: _____

If this is an emergency medication, i.e. inhaler, EpiPen®, etc., has student been instructed to self-administer and may he/she do so? Yes _____ No _____

Physician's Name - Printed (prescription only): _____ Date: _____

Physician's Signature: _____ Telephone: _____

To be completed by Parent or Guardian (initial appropriate option)

Option I: _____ (initial) I request and authorize the school nurse/aide or trained personnel at the above named school to store and administer the medication/treatment prescribed on this form to my child. I understand the medication must be provided in a bottle, identifying the name and telephone number of the pharmacy, the patient's name, physician's name, drug name and dosage of the drug to be taken (if prescription), or in the original bottle (if over-the-counter). I understand the school and individuals involved will not be held liable for any adverse effects of the medication. I give permission for communication that may be necessary between the prescribing physician and school nurse/trained staff to insure safe medication administration for my child. In the event of a school -sponsored field trip I understand that my child's medication will be sent with designated personnel (typically the teacher) in the amount to be administered during the activity unless otherwise specified by me. In addition, I understand medication(s) cannot be stored at the school over summer breaks and must be picked up by me or other arrangements made the last day of school.

Option II: _____ (initial) I request and authorize my child to keep and self-administer his/her own medication at school.

(6th – 12th Grade Only) I relieve the school district and personnel of all responsibility associated with this self-administration. I understand this option is available only when it will not be a potential health risk to my child or others. Medications which can be self-administered include physician-ordered inhalers and EpiPens®, and over-the-counter medications (e.g. Ibuprofen, Acetaminophen, cough drops, Tums). *Prescription medications may not be self-administered unless specifically approved by the school nurse*. Except for inhalers and EpiPens®, *only medication for one day at a time may be brought to school*. **(This option is only available to middle school and high school students).**

Parent or Guardian Signature: _____ Date: _____