BLANCHARD PUBLIC SCHOOLS

Authorization Consent to Administer Medications to Student

School Year 2017-2018

Please fill out Medication Instructions on other side. Use a separate authorization form for each medication.

Student Name ____________________________ ______________________________ ________
(Last) (First) (M.I.)

Grade _________________ Teacher ___________________________ Date of Birth ___________________________

Parent/Guardian Name ___________________________________ Daytime Number ________________________

Allergies ____

I am the parent/guardian of ______________________________. I give my permission for him/her to take the following prescribed medication while in Blanchard Public School. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medication during school time. I hereby release Blanchard Public Schools and its employees from any claims or liability connected with its reliance on this permission and agree to hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the licensed prescriber listed below.

____ __________________________
(Parent/Guardian Signature) (Date)

(For Use By Licensed Prescriber __ONLY__)

Relevant Diagnosis ___________________________________ Medication ____

(List dates to be given) from _________________________________ to ____

________________________ Every day at school ______________________ Episodic/Emergency Events **__ONLY__**

Dosage (Amount) ____ Route _______________________

Time(s) of Day ____

A. Serious reactions can occur if the medication is not given as prescribed ___YES ___NO
If yes, describe:

B. Serious reaction/adverse side effects from this medication may occur ___YES ___NO
If yes, describe:

Action/Treatment for reactions: ____

Report to you: ___YES ___ NO (Drug information sheet may be attached.)

Special Handling Instruction: ___ Refrigeration ___ Keep out of sunlight ___ Other:________________________

Asthma/Diabetic __ONLY__

This student is both capable and responsible for self-administering this medication:
___ NO ___ YES; Supervised ___ YES; Unsupervised
This student may carry this medication on his/her person: ___YES ___NO

Date _____________ Telephone Number _______________________ Emergency Number ______________________

Licensed Prescriber's Name (Please Print) ____

Licensed Prescriber's Signature ____

BLANCHARD PUBLIC SCHOOLS

Medication Dispensing Form 2017-2018

Student Name ____ Teacher / Grade ______________________________

Medication Instruction:

Medication _________________________________ Dosage ______________________ Time(s) ________________________

Count Pills Brought in By Parent and Record Below:

#	DATE	#	DATE	#	DATE	#	DATE	#	DATE	#	DATE	#	DATE	#	DATE	#	DATE	#	DATE

DATE	TIME	ADMIN. BY	DATE	TIME	ADMIN. BY	DATE	TIME	ADMIN. BY	DATE	TIME	ADMIN. BY

SIGNATURES OF THOSE ADMINISTRING MEDICATIONS

Initials Signature

_____ ____________________

_____ ____________________

_____ ____________________

_____ ____________________

_____ ____________________

COMMENTS:

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