

BLANCHARD PUBLIC SCHOOLS
Authorization Consent to Administer Medications to Student
School Year _____

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 _____

