KINGSLEY AREA SCHOOLS

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student's Name_____ Birth date_____

School Building _____ Grade_____

PHYSICIAN'S ORDER:

Diagnosis / Purpose of Medication_____

_____

Name of Medication_____

Dosage_____ Frequency_____ Route_____ Time_____

_____

Anticipated Duration_____(if INDEFINITE, please state so)

This Prescription is: (please check one)

_____Initiation of Therapy _____Adjustment of Dosage

_____Maintenance Dose _____Discontinuation of Therapy

Comments regarding this prescription: (include adverse reactions, precautions, instructions, etc.)

_____

_____

Physician's Signature: _____Date_____

Verbal Order: (Short term prescriptions only.)

Written Verifications. Date requested_____ Date Received_____

Principal's (or Designee's) Signature_____ Date_____

The undersigned parents/guardian authorize(s) the Kingsley Area School District through its administrators to administer medication to my child. It is understood that the undersigned parents/guardian shall notify the Kingsley School District in writing in the event the prescribed prescription shall be discontinued or modified. The medication must be brought to school by a responsible adult, in a container appropriately labeled by the pharmacy. (Student transporting of medication is not allowed.) Refill of the prescription shall be the responsibility of the parent or guardian. The undersigned releases the Kingsley Area School District and shall indemnify said school district and its employees from any liability or damage, which may result to the student from the administration of said medication.

Signature of Parent or Guardian_____ Date_____

THIS FORM IS VALID FOR THE CURRENT SCHOOL YEAR ONLY.