MEDICATION AUTHORIZATION

Carbondale Community High School
Phone: 457-3371, ext. 252
Fax: 457-8931

Student Name: _____ **DOB:** _____

Parental Authorization:

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Carbondale Community High School and its employees and agents to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the school district), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is to be administered or attempted to be administered, I waive any claims I might have against the school district, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against all claims, damages causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

_____ _____
Parent Signature **Date**

_____ _____
Print Name **Contact Numbers**

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School medications are administered following these guidelines:

Physician/Prescriber signed and dated authorization to administer the medication.
Parent signed and dated authorization to administer the medication.
Medication is in original labeled container as dispensed.
Medication label contains student's name, name of medication, directions for use.
Annual renewal of authorization and immediate notification, in writing, of changes.

Physician Authorization:

_____ _____
Medication Diagnosis

_____ _____
Begin Date Expected Side Effects, if any

_____
Administration Instructions

_____ _____
Physician Signature Date

_____ _____
Print Name Phone Number

Updated 1/27/12