AUTHORIZATION/PARENTAL CONSENT FOR ADMINISTERING PRESCRIBED MEDICATION

All Ballard County schools must have the parent/guardian's authorization for a nurse to administer prescription medications or, in his/her absence, the principal and/or designated staff to administer medications. Medications must be in their pharmacy-prepared containers and labeled with the name of student, name of drug, strength, dosage, frequency, name of physician/dentist/ARNP/PA. Please complete both the front and back of this form. To view the district's policy on medication administration, please contact Bob Wilson at 665-8400, ext. 2014, or ask the school nurse.

Date: _____

Name of student: _____ Date of birth: _____

Grade: _____ Teacher: _____

Condition for which the drug is needed: _____

_____

Drug name and method of administration: _____

_____

Time of administration: _____

Medication start date: _____ Medication end date: _____

Special storage requirements: _____

_____

Restrictions and/or side effects: _____

_____

This student is both capable and responsible for self-administering this medication:

No _____ Yes-Supervised _____ Yes-Unsupervised _____

Physician's name: _____ Phone: _____

Address _____

To be completed by parent/guardian:

I give permission for _____ to receive the above prescription medication at school according to standard school policy. I understand that I have the ultimate responsibility for providing the school with an adequate supply of this medication to enable the physician's orders to be followed. I understand that ALL medication must be delivered to the school by a parent/guardian, either to the main office or school nurse's office. **Prescription medication must be in the original pharmacy bottle with the correct name, medication, dosage and time(s) of administration**. I hereby release Ballard County Schools and its employees from any claims or liability connected with its reliance on this permission form, and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I am responsible to notify the school in writing of any changes made regarding my child's medication or medical needs, and to pick up any unused medication at the end of the school year.

Signature: _____ Date: _____

Relationship to child: _____ Phone: _____

2015-16 STUDENT MEDICATION LOG

Name_____ Parent_____ Home/Cell/Work_____

Physician _____ Phone _____ Allergies _____

Medication_____ Route _____ Dosage _____ Time to be given _____

Discontinued medication _____ Parent/Guardian notified to pick-up meds _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sept																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
April																															
May																															

Subs: Name _____ Initials _____
Name _____ Initials _____
Name _____ Initials _____
Name _____ Initials _____
Name _____ Initials _____

CODES:

A = Absent
N = None available
W = Dose withheld
O = No-show
D = Early dismissal
F = Field trip
X = No school