CHIPPEWA VALLEY SCHOOLS

Medication Administration Authorization Form

Prescription and Over the Counter (OTC) Medication

Name of Student:_____ Date of Birth:_____ Grade:_____

School:_____ Date: _____

Physician/Licensed Health Care Provider Orders:

~Only one medication order per form~

Name of Medication:_____

Dose:_____ Route: _____ Time:_____

Reason for medication (optional):_____ Daily ☐ Temporary ☐ PRN ☐

Date start medication:_____ Date stop medication: _____

Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other ☐

Special Instructions:

_____ _____

Signature of Physician Date Printed name of Physician

Physician's Telephone Number: _____

To be completed by Parent or Legal Guardian:

I do hereby request and authorize administration of medication to be given to the above-named student.

- I will assume responsibility for safe delivery of the medication to school.
- I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- I release and agree to hold the Board of Education, its officials, and it employees harmless from any and all liability, foreseeable or unforeseeable, for damages or injury resulting directly or indirectly from this authorization.
- As needed (PRN) medication parent will be notified before administration

_____

Signature of Parent or Legal Guardian Printed name of Parent or Legal Guardian

_____

Daytime phone number Home phone number Cell phone number