Medication Authorization Form

PHYSICIAN SECTION

Student's Name:	
Diagnosis/Reason For Medication:	
Name Of Medication:	
Type Of Medication (tablet, liquid, capsule, inhaler, insulin, injection, etc.):	
Dosage:	
Time(s) To Be Taken:	
Specific Directions/Possible Side Effects:	

Please check the box below that applies to this student:

□ This student is both capable and responsible for self-administering this medication at school. Furthermore, I certify that this student has been instructed in the use and self-administration of the above medication. He/she understands the need for this medication and is able to use this medication independently.

□ This student needs assistance of District personnel to administer this medication at school.

Physician Name:_____ Telephone Number:_____

Physician Signature:_____Date:_____

PARENT/LEGAL GUARDIAN SECTION

Please check the box below that applies to this student:

□ I give permission for my child to self-administer the medication listed above.

□ I request that the above medication be administered to my child by District personnel.

I understand that any change in this prescription will necessitate a new medication authorization form to be completed. I understand that administration of medication will be handled according to Policy # 370.20. In accordance with the Family Education Rights and Privacy Act of 1974 (FERPA), I hereby give permission for Minidoka County Joint School District # 331 to release to, obtain from or exchange with any appropriate person or agency, any confidential, educational, psychological and/or medical information or records regarding my child thus permitting District personnel to communicate with my child's health care providers.

Parent/Legal Guardian Name:_____
Date:_____