Adams 12 Five Star Schools

PARENT/LEGAL GUARDIAN'S RELEASE FOR ADMINISTRATION OF MEDICATION OR PROCEDURE AT SCHOOL AND AUTHORIZED PRESCRIBER SIGNED ORDER

Health Services

The undersigned **parent/legal guardian** of _____, Date of Birth_____,
(Student's Name)

hereby requests Personnel employed by Adams 12 Five Star Schools to administer or supervise administration of medication or a procedure as ordered by an authorized prescriber. **This is effective for the current school year.**

It is required by Adams 12 Five Star Schools, as a condition to its agreement to administer any medication, that the medication be prescribed by a licensed physician either MD or DO, dentist, or other authorized prescriber and that it will be furnished by the parent/guardian of the student in a container dispensed by a pharmacy or in an original over-the-counter container which is labeled with the student's name, medication name, dosage, and time when the medication is to be given. It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. By signing this release I hereby authorize employed personnel of Adams 12 Five Star Schools to contact the authorized prescriber, if necessary, to clarify any written order. Adams 12 Five Star Schools policy requires that non-emergency medication, both prescription and over-the counter, be kept in a locked area of the school Health Office. The medication will be administered by Adams 12 Five Star Schools personnel according to the authorized prescriber's written order/treatment plan, parent permission, and as specified in Superintendent Policy 5420.

School: _____ Phone: _____ Fax: _____

PARENT Signature: _____ Date: _____

AUTHORIZED PRESCRIBER'S SIGNED ORDER FOR MEDICATION or PROCEDURE ADMINISTERED AT SCHOOL

Medication Name: _____

Medication Dosage:

1. _____ MG Tablets/Chewable/Capsules/Liquids/Ampules

OR

2. Inhalers - Puffs to be given: _____ puffs

Route:

☐ Oral ☐ Topical ☐ Rectal ☐ Inhaled ☐ Nebulizer ☐ G-tube

Procedure: ☐ G-Tube Feeding ☐ Catheterization ☐ Pulse Oximetry

Other:_____

Time to be given:_____

Prior to exercise: ☐ Yes ☐ No

May be repeated every _____

Special instructions:_____

_____

Start Date: _____

Stop Date: _____

Purpose:

Possible Side Effects:

Other Comments:

PRINTED NAME of Authorized Prescriber:_____

Authorized Prescriber Signature:_____ Date: _____

Office Address: _____ City: _____ Zip: _____

Office Phone: _____ Office Fax: _____