AUTHORIZATION FOR STUDENT TO RECEIVE MEDICATION(S) DURING SCHOOL DAY

Prescription Medications/Over-the-Counter Medications*

(AUTHORIZATION - MEDICAL PROCEDURES ON OTHER SIDE)

Student: _____ Birth Date: _____

Home Address: _____ Phone: _____

School Program: _____ Teacher: _____

Medication(s)	Dosage Amount	Reason for Medication(s)	Hour(s) or Time(s) to be Dispensed

Effective Dates: (current school year only) From: August 1 To: July 31

☐ Yes ☐ No **Student requires school personnel to hand medication and water to student or provide additional assistance as needed.**

List other medical concerns that IU personnel should know: _____

_____

Physician name printed | **Physician's signature** | **Date**

Practice Name and location | **Phone** | **Fax**

(Physician authorization is required for all medications, including over-the-counter and supplements.)

Parent/Guardian, by signing below, I agree:

1. That I am primarily responsible for the administration of 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 IU13 and its employees and agents to administer medication to my child pursuant to this authorization.
2. I acknowledge that it may be necessary that medication be administered to my child by individuals, other than a school nurse, and I hereby specifically consent to such practice.*
3. I authorize written and/or verbal communication between the ordering physician and school nurse regarding medication and treatments listed above.
4. I agree to indemnify and hold harmless IU13 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of medication to my child.

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____ Date: _____

*Procedures administered pursuant to this form may be administered by IU13 personnel who have received appropriate training. It is understood and agreed that IU personnel acting in such capacity are acting within the scope of their employment relationship with IU13. No such personnel shall be liable to any student, parent or guardian of such student for any civil damages for personal injuries resulting from acts or omissions of IU13 personnel acting in conformance with approved IU13 policies governing the administration of medications or medical procedures to students.

AUTHORIZATION FOR STUDENT TO RECEIVE MEDICAL PROCEDURES DURING SCHOOL DAY

Medical Procedures

(AUTHORIZATION – MEDICATION ON OTHER SIDE)

Student: _____ Birth Date: _____

Home Address: _____ Phone: _____

School Program: _____ Teacher: _____

Name of Procedure: _____

_____

Purpose of Procedure: _____

_____

_____

Description of Procedure: _____

_____

_____

Frequency and time(s) to be performed during the school day: _____

Effective Dates: (current school year only) From: August 1 To: July 31

Physician name printed	**Physician's signature**	**Date**
Practice Name and location	**Phone**	**Fax**

Parent/Guardian, by signing below, I agree:

1. That I am primarily responsible for the administration of medical procedures 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 IU13 and its employees and agents to administer medical procedures to my child pursuant to this authorization.
2. I acknowledge that it may be necessary that medical procedures be administered to my child by individuals, other than a school nurse, and I hereby specifically consent to such practice.*
3. I authorize written and/or verbal communication between the ordering physician and school nurse regarding medication and treatments listed above.
4. I agree to indemnify and hold harmless IU13 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of medical procedures to my child.

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____ Date: _____

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