**Lowndes County School District Medication Authorization Form**

Medication will be administered in school ONLY when a student must remain there. Medication should be brought to school by the parent/guardian for a student ONLY WHEN IT IS AN ABSOLUTE NECESSITY.

This policy ensures that students receive the necessary medication according to their physician’s orders and ensure maximum safety for all concerned. Please understand that your signature on this form authorizes other school personnel to supervise your child with medication administration when the school nurse is not available.

One form must be completed and signed by a parent AND physician ANNUALLY for EACH medication. All medications must be picked up by the parent/guardian at the end of the school year or they will be disposed of.

**MEDICAL PROVIDER STATEMENT**:          Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time of Administration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Termination Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Side Effects/Special Instructions for Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\* The student named on this form is authorized to carry an ***ASTHMA INHALER*** on his/her person and self-administer it. \_\_\_**YES** \_\_\_**NO**

\*\* The student named on this form is authorized to carry an ***EPI PEN*** on his/her person and self-administer it. \_\_\_ **YES** \_\_\_**NO**

**\*\* This student demonstrates a full understanding of the proper use of this medication.**

Medical Provider’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_

Medical Provider’s Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN STATEMENT:**             I hereby request that this medication be given to my child according to the physician’s instruction. **I agree to furnish the necessary medication in a pharmacy/original labeled container, to provide replacement medication as necessary, and to provide a new physician’s statement if there is ANY change in the medication, dosage, administration time, administration route or special instructions regarding the medication. I agree to provide a written statement if the medication is to be discontinued.** I understand that other designated personnel (other than school nurses) may give my child’s medication or supervise the child with self-administration of the medication. I waive any liability claim against school staff assisting my child in taking medication.

 Parent’s/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_