PRESCRIPTION OR OVER THE COUNTER (OTC) AUTHORIZATION FOR MEDICATION ADMINISTRATION
West Fargo Schools

When it is determined by the physician that medication must be taken during the school hours this form is to be completed.

Student_____ Date_____
Grade_____ Date of Birth_____ School_____
Allergies_____ School Year_____

PHYSICIAN'S ORDER or Clinic to provide a current computerized medication list to the school.

Medication_____ Dose_____ Route_____

Time /Frequency_____ Continue Until_____

Reason for Medication/Diagnosis_____

Special Instructions_____

Major Side Effects/Reactions_____

Action/treatment for side effects_____

Special handling instructions:

Refrigeration Keep out of sunlight Other_____

Date_____ Physician Name (Print) _____

Physician Signature*_____

Phone_____ Address_____

*Physician signature on OTC medications is required only if dosage is not within the manufacturer's recommended guidelines.

Amount of Medication Received _____Medication Expiration Date_____

I request this medication be given to my child in the manner specified herein. I give permission to school personnel to administer the medication. I understand that the administration of the medication will not necessarily be done by a nurse. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this medication. I further agree that the school personnel or nurse may contact the prescriber as needed and that medication information may be shared with school personnel who need to know. In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the administration of medications to the above named student from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described medications. Law prohibits the school from making further disclosure of my child's health information unless the school obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the healthcare agencies/persons and school listed above. My revocation will be effective upon receipt but will not be effective to the extent that the school or others have acted in reliance of this authorization. I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's health record. The information will be shared with individuals working at or with the school for the purpose of providing safe, appropriate, and least-restrictive educational settings and school health services and programs.

Date_____ Parent /Guardian_____

Phone (H)_____(C)_____(W)_____

Address_____

Alternate family member's emergency contact name _____

Phone _____Please Circle: Home Work Cell