ANNUAL AUTHORIZATION FORM to ADMINISTER MEDICATION

Name of student: ____

Medication: ____

Time medication needs to be given: ____________a.m. __________p.m.

To be given from (date): _____________________ to _______________________

Significant information (include side effects, toxic reactions, etc.):

____

____

Contraindications for administration: ____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

- Contact the parent at: ____
- Contact the physician's office at: ____
- Take child immediately to the emergency room at:_______________________________________

This medication will be furnished by the parent or guardian within a properly labeled container by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time to be given).

___________________________________ ______________________

Physician's Signature Date

PARENT'S PERMISSION: I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release Pioneer Springs Community School and its employees from all liability that may result from my child taking the prescribed medication.

________________________________ ____________________

Parent or Guardian Signature & Date