Dee-Mack CUSD #701

Medication Authorization Form

School: Dee-Mack Primary and Jr. High

Phone 359-4321 fax 359-4015

Child Name: _____ **Date of Birth:** _____ **Grade:** _____
Physician: _____
Address: _____
Telephone: _____

As the parent/guardian I understand that it is the policy of the district that as a regular and normal practice, medication should not be administered to a student at school or when a student is involved in school activities. However, in order to provide for the critical health and well being of students, under certain circumstances, medication may be administered during school hours by administrative personnel, administrative designee, or self administered by the student. I further release Deer Creek Mackinaw CUSD, its Board of Education, and members thereof, and its employees shall be indemnified and held harmless from any and all claims arising from the administration of said medication.

Medication must be brought to school in the original container, labeled by the pharmacist or licensed prescriber.

I request that my child be assisted in taking medication(s) described below at school by authorized persons or be permitted to medicate herself/ himself as also authorized by me and my physician I further consent to the sharing of relevant medical information between the school and the physician's office.

Date Parent/Guardian Signature Phone

The following section must be completed by the **PHYSICIAN**

All items must be completed before the school can approve the administration of medication.

Medication:	
Purpose of medication/ diagnosis:	
Dose/ Frequency:	
Other medications the child receives:	
Can child medicate themselves?	
Side effects:	
Length of time treatment is recommended:	
Must this medication be administered at school in order to allow the child to attend school or to address the student's medical condition that may arise at school?	

Date Physician's signature