MARTENSDALE-ST. MARYS SCHOOL DISTRICT

Authorization to Administer Medication at School

Student's Name _____ Grade _____

Teacher's Name _____ Building _____

Medication _____ Dosage _____

Medication _____ Dosage _____

Medication _____ Dosage _____

Time to be given _____ a.m. Time to be given _____ p.m.

Date from _____ to _____

Medication will be dispensed in accordance with the Code of Iowa and the 1985 Iowa Board of Nursing Declaratory.

PRESCRIPTION: The medication must come with written permission from the parent and in the original container labelled with:

1. Name of pupil
2. Name of medication
3. Directions for use
4. Name of Physician
5. Name and address of pharmacy
6. Date of prescription

OVER-THE-COUNTER: The medication must come with written permission from the parent and in the original container.

I request the above student be given the above medication at school and school activities by qualified staff (this includes all field trips), according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of a administration of medication where the person administering the medication acts as an ordinarily reasonable prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment or it will be properly destroyed.

_____ _____

Parent/Guardian Signature Date

_____ _____ _____

Address Home Phone Work Phone

Additional information: _____

_____