AUTHORIZATION FOR MEDICATION ADMINISTRATION AT SCHOOL

Spearfish School District 40-2

Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Medication: _____ Dosage: _____

Reason for Medication: _____ Time to be taken: _____

Possible Side Effects: _____

Length of time medication is prescribed: _____

Additional Instructions: _____

I grant permission for the Spearfish School District 40-2 to administer medication to the student above as prescribed by a health care provider. I understand that I must provide all medication in its original pharmacy labeled container and am responsible for transporting all medications to and from the office. I hereby certify that the student identified above has previously had at least one dose of the prescribed medication listed above and did not have an adverse reaction from it. I understand that my child assumes responsibility for going to the school office at the specified times for medication. I release and waive any and all claims which I now have or may hereafter have against the Spearfish School District 40-2 and its employees arising out of the administration of or failure to administer the medication to the student or any adverse reaction by the student to the medication.

_____ _____

Parent / Legal Guardian Date

Medication Check-Out

Dosage Remaining/Returned: _____ Date: _____

Parent / Legal Guardian: _____Staff: _____