School Year: _______

Astoria School District 1C
Authorization for Administration of Medication at School

Student Name: ____________________ DOB ___/___/_____ School: _____________ Grade: ____

Astoria School District medication policy requires that **all medications** (prescription and non-prescription) shall be administered during school hours only when required by the student's health condition. Parents/Guardians must provide written permission each school year. All prescription medications must be in the original prescription container with the student's name, drug, medication time and the name of the prescribing healthcare provider. All non-prescription medication (i.e. Tylenol, cough drops, etc) must be in the original container or package. Students are allowed to self-administer medication if it is indicated necessary in writing by both the healthcare provider in the written order and by the parent in the Medication Authorization Form. Whenever possible, the parent or guardian should make arrangements so that it is **not** necessary for school personnel to administer a medication to a student.

Please complete and sign.

Medication: _____________________________________Reason given:_________________________

Amount to be given at school: _____________________________ (i.e.; 1 tablet every 6 hours)

Time to be given at school:______________________________________Prescription:___Y___N

Inhaler self-administered (written permission from healthcare provider & parent): ______

Healthcare provider: ______________________________ Phone: ____ _________

Start date: ___/___/____ End date: ___/___/_____

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I understand that in the absence of the school nurse, other school personnel will administer the medication. I agree to defend and hold the school district employees harmless from any liability for the results of the medication or the manner, in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I will notify the school immediately if the medication is changed and understand that the nurse may contact the healthcare provider or pharmacist regarding this medication. I understand that this medication will be destroyed unless picked up by the last student day of the school year.

X ____ Signature of Parent/Guardian

Date: ___/___/_____ Home/Cell Phone: _______________ Work Phone: _________________

Medication Discontinued:___per parent request___completed treatment___end of school year

Medication Disposition:_____picked up by parent_____disposed of _____held in office

Staff Signature: ____ Date: ___/___/_____