Carman-Ainsworth Community Schools
Authorization to Administer Medication at School
Required for all Prescription and Non-Prescription Medication

School:
❍**High School** 591-3240/591-3215 (Fax)
❍**Middle/Atlantis** 591-3500/591-3594 (Fax)
❍**Randels Elem** 591-3250/591-3225 (Fax)
❍**Dillon Elem** 591-3590/591-3835 (Fax)
❍**Dye Elem** 591-3229/591-3310 (Fax)
❍**Rankin Elem** 591-4605/591-8440 (Fax)

Student's Name_____ **DOB** _____/_____/_____

Teacher/First Hour_____ **Grade**_____ **School Year:** _____

To be completed by **Physician**

Name of Medication:_____

Order: (frequency/time) _____ **Dose/Concentration:** _____

❍ **Asthma/Anaphylaxis see attached plan for additional dosing and frequency**

Route of Medication: ❍Tablet/Capsule ❍Liquid ❍Inhaler ❍Injection ❍Nebulizer ❍Other _____

Reason for Medication: (optional) _____

Possible side effects: ❍None Anticipated ❍Yes, explain _____

Special storage: ❍None ❍Refrigerate ❍Other_____

Start Date: ❍Once both medicine and completed form are received ❍Other date_____

Stop Date: ❍End of school year ❍Other date (if sooner)_____

Self-Administration (Emergency medications only) This student is capable and responsible for carrying and self-administration of this medication:

❍Yes ❍No ❍Yes, with supervision (may self-administer, medication to remain with staff)

Physician Signature_____ **Phone**_____

No Stamped Signature

Physician Name_____**Date**_____

To be completed by **Parent/Guardian**

I request that (student's name)_____ receive the above medication according to school policy. I give permission for exchange of verbal and written communication between the physician and the school nurse and/or designated school staff regarding my child's medication. I request that my child be assisted in taking the medication described above or be permitted to carry and self-administer as authorized by the physician above. I agree to notify the school in writing if the medication, dosage, schedule, or procedure is changed or eliminated. I will assume responsibility for the safe delivery of the medication to school. I release and agree to hold the Board of Education, its officials, and its employees harmless from and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.
*Medication will be destroyed one week after parent notified to pick up or at the end of each school year.

Parent/Guardian Signature_____ Date_____

Parent/Guardian Name_____Phone_____

*One Authorization to Administer Medication form must be filled out for **EACH** medication the student may take at school

For Office Use Only

❍Parent signed ❍Dr. signed ❍Med received **and/or** ❍Student carries(labeled) Updated SK, 10/21
❍Synergy (s) ❍Additional Staff notified: _____ Initials/Date _____