

Emery County School District



Policy: JLCD-E1 – Authorization of School Personnel to Administer Medications

Date Adopted: 1 February 2012
Current Review / Revision: 1 February 2012

Name of Student _____ Date of Birth _____

Address _____ Home Phone _____

Parent/Guardian _____ Work Phone _____

School/Teacher _____

Name of licensed medical provider completing form: (please print)

Licensed Medical Provider's Statement:

1. Name/type of medication _____
2. Dosage/amount to be given _____
3. Frequency/times to be administered _____
4. Duration (week, month, indefinite, etc.) _____
5. Anticipated reactions to medication (symptoms, side effects for under-dose / overdose, etc.)__

I hereby verify that the medication described above is medically necessary for the student listed on this form.

Signature of Licensed Medical Provider

Date

Parent/Guardian Request and Approval

I hereby understand and give permission for the above named student to receive the specified medication as stated in the above instruction from the medical provider. I understand that the school administration will designate a specific staff member to administer medication, train staff, assure proper identification and safekeeping of the medication, and maintain records of such administration of medication.

I further understand that the school personnel who provide assistance in the administration of the specified medication, or employer of such personnel, are not liable, civilly or criminally, for any adverse reaction suffered by my child as a result of taking the medication so indicated and/or discontinuing the administration of the medication in keeping with the procedure outlined above.

Signature of Parent/Guardian

Date