MATANUSKA-SUSITNA BOROUGH SCHOOL DISTRICT
MEDICATION AUTHORIZATION

It is the policy of the Matanuska-Susitna Borough School District that medication may be dispensed in school only when the student's health requires that the medication be given during school hours. Medication to be dispensed at school must be in an original, properly labeled prescription bottle. **This form, or a written statement signed by the health care provider, is required for all medication prescribed for more than two weeks.** This form must be updated annually. All medication will be destroyed unless picked up by the end of the last student school day of this year.

School Nurse_____ School_____ Phone_____ Fax_____

Name of student _____

Medication name _____

Dosage, route of administration _____

Time to be given at school_____

For treatment of_____

Possible side effects_____

Special instructions_____

Date prescribed_____ Date of discontinuance_____

_____ _____

Date **Health Care Provider Signature**

_____ _____

Phone and Fax Numbers **Health Care Provider Printed Name**

TO BE COMPLETED BY THE PARENT AND RETURNED TO THE SCHOOL NURSE BEFORE MEDICATION MAY BE ADMINISTERED.

Name of pharmacy and RX number (from pharmacy container) _____

I hereby give permission for my child to receive the above listed medication at school and/or during school sponsored activities, as prescribed by my child's health care provider. Permission is also given for the school nurse to contact the health care provider regarding this treatment.

I understand all medication will be administered by the school nurse or designated school employee in the absence of the school nurse. The school nurse will train the following staff. I delegate the staff members listed below the task of administering prescribed medication in the absence of a registered nurse.

STAFF MEMBERS TRAINED Name	Title	Location/Room #	Trained By

I agree to save, defend and hold harmless the Matanuska Susitna Borough School District, its employees, elected or appointed officials, from any liability or damages as a result of the administration of this medication or the effects of the medication. I agree to notify the school nurse immediately of any changes in medication dosage, adverse or ill effects from the medication, or discontinuance of the medication.

_____ _____

Date **Parent/Guardian Signature**