**RINGGOLD SCHOOL DISTRICT HEALTH SERVICES**
**MEDICATION AUTHORIZATION FORM**

**PARENT/ GUARDIAN PLEASE: Complete this form if it necessary for your child to receive medication during school hours. <u>All prescription and over-the-counter medications must be accompanied by a written physician order and parent/guardian permission.</u> Prescription medication must be in a container with the pharmacy label attached. Over- the- counter (non-prescription) medication must be in the original labeled package. A new form is required for each new school year and for any changes in the following information.**

## *PHYSICIAN/CRNP/PA/DENTIST INSTRUCTIONS FOR MEDICATION IN SCHOOL*

Student Name _____ School _____ Grade____HR____

Address _____ Birth Date _____M/F_____

Diagnosis _____ Medication Allergies _____

Medication _____ Dose_____ Route _____

Time /frequency _____(list indications for prn)

Duration of medication: Entire school year _____OR from the dates:___/___/20__to __/__/20__

Precautions and adverse reactions _____

Emergency response for serious reaction _____

**<u>Inhaler</u>**: The child was instructed and is able to demonstrate correct inhaler use. He /she is responsible and will carry the inhaler for independent self-administration. **YES_____ NO____**

**<u>EpiPen</u>**: The child was instructed and is able to demonstrate correct EpiPen use. He /she is responsible and will carry the EpiPen for independent self-administration. **YES_____ NO____**

**<u>Insulin</u>**: The child was instructed and is able to demonstrate correct Insulin use. He /she is responsible and will carry the Insulin for independent self-administration. **YES_____ NO____**

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**Physician/CRNP/PA/Dentist Signature Date Phone**

## ***<u>PARENT/GUARDIAN AUTHORIZATION</u>***

I request that my child take the medication in school as directed on this form. It is the student's responsibility for coming to the health office to receive medication. I acknowledge that the school nurse may not in every instance administer the medication. I release and indemnify the school district, it's officers, agents and employees from any and all liability resulting from medication administration The parent/guardian of a "protected handicapped student", as that term is defined within the Pennsylvania Department regulations found at 22Pa. Code Chapter 15, is not required to acknowledge or execute such a release or indemnification agreement. I also authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee), the health care provider and appropriate staff.

**Students who carry and self-administer an asthma inhaler, EpiPen or Insulin in school must be able to demonstrate the following:**

1. Proper and correct use/administration of the medication in the dose, time and frequency as prescribed on this form
2. Notify the school nurse immediately following each use of the medication
3. Keep the medication in a specified location and will not share medication with other students

If at any time the student is unable to demonstrate correct use of the medication as prescribed above, shows signs of irresponsible behavior or if there is a safety risk, the principal has the right to confiscate medication and withdraw the privilege to self-administer.
I acknowledge that the school has no responsibility for ensuring that self-administered inhaler medications are taken.

**FOR INHALER, EPI PEN, and INSULIN ONLY: I request that the school comply with the prescription above that permits my child to carry and self-administer the medication.** **(Circle one): YES NO**

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**Parent/Guardian Signature Date Phone (home, work, cell)**