

Genoa-Kingston CUSD # 424
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Student Name (Last) (First) (M.I.) (D.O.B.)

School medications are administered following these guidelines:

- *Physician must sign and date authorization to administer medication.
- *Parent/guardian must sign and date authorization to administer medication.
- *Medication must be in the original, labeled container as dispensed from pharmacy.
- *The label must contain the name of the student, name of the medication, directions for use and date

Only medications approved by the FDA will be administered at school.
Controlled medications i.e. Ritalin, Adderall, Concerta must be transported to school by an adult.
Annual renewal of authorization is mandatory and all medication changes must be in writing.

Physician Authorization:

Medication	Dosage	Time of Administration
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Diagnosis or intended effect of medication	Side effects, if any
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Other medication(s) student is taking

Discontinue Date

Physician Signature

Date Signed

Physician Emergency Phone #

Parent/Guardian Authorization:

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event I am unable to do so or in the event of a medical emergency, I hereby authorize Genoa-Kingston CUSD # 424, its employees and agents, on my behalf and stead, to administer, or attempt to administer to my child (or allow my child to self administer, while under the supervision of employees and agents of the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered, or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of the said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts of said medication.

Parent/Guardian Signature

Home Phone

Parent/Guardian Address

Work/Cell Phone

Date