GUTHRIE PUBLIC SCHOOLS Date school received _____

MEDICATION AUTHORIZATION

Student: _____ DOB: _____ Grade: _____

School: _____ Teacher: _____

It is the policy of Guthrie Public Schools that prescription and nonprescription medication will only be administered by school staff with written authorization of the child's legal custodian and written instructions from the child's physician. The medication must be in the original container with proper labeling: name of child, name of medication, dosage, and time to be taken. The Guthrie Public School Medication Authorization form must be completed and returned to the school principal/designee. A new form must be completed for each medication. The school will not allow a child to take medication that is improperly labeled or is unauthorized.

***TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER:**

Name of Medication: _____

Dosage/amount to be given: _____Time to be given: _____

Duration: (week, month, indefinite, etc.) _____

Possible side effects: _____

_____ _____ _____

Physician's Signature **Physician's Name (please print)** **Date**

_____ _____

Phone Number **Fax**

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby request and give my permission for the above named school to administer the medication prescribed on this form to my child. I further understand that I will be responsible for picking up any medication at the end of the school year. Any medication left at school after June 1st will be discarded utilizing proper procedure.

_____ _____

Parent/Guardian Signature Date

- **COMPLETE THE SECTION BELOW ONLY IF PRESCRIBING ASTHMA, ANAPHYLAXIS OR DIABETES MEDICIATION TO BE CARRIED BY THE CHILD**

SELF-ADMINISTRATION OF ASTHMA, ANAPHYLAXIS AND DIABETES MEDICATION ONLY

***TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER:**

- **This child is both capable and responsible for self-administering the medication: No ____ Yes ____**
- **This child may carry this medication on his/her person: No _____ Yes _____**
- **The above child has been instructed in the proper uses of his/her medication and it is my professional opinion that this child is capable of self-administering the medication and shall be allowed to carry and use that medication by himself/herself : No _____ Yes _____**

_____ _____

Physician's Signature (Required) **Date**

- **The school district shall incur no liability from your child self-administrating medication at school.** ***The parent or guardian of the student is to provide the school an emergency supply of your child's medication.***
- The **pharmacy label** must be attached to the medication.

Parent/Guardian signature below is granting your child permission to self-administer his/her medication at school.

_____ _____ _____

Parent/Guardian Signature Date Contact Phone

I will not knowingly allow another student to take my medication. I will administer medication according to physician's directions.

_____ _____

Student Signature Date