## Medical Authorization

### Prescription Medication Release

This medication authorization is effective for one school year and must be renewed annually.

Student Name: _____ DOB: _____ Age: _____ Grade: _____

Medication: _____ Dosage: _____ Route: _____

Frequency: _____ When is it given? _____ _____

Possible side effects: _____ Reason for Medication: _____

Prescribing Physician: _____ Physician Phone: _____

**• Students are not allowed to carry medicine with them at any time •**

- I understand that the first dose of the prescribed medication may not be given at school.
- I authorize the school nurse or clinic representative to confer with the licensed prescriber and correspond regarding my child's health and treatment as it pertains to the medication/diagnosis.
- I understand that the medicine prescribed will be provided to the school in the "original" pharmacy labeled container with the appropriate identifying information as written/stated above.
- I understand that the prescribed medication must be delivered and given to the school nurse or school personnel by parent/guardian and not by the student,
- I give permission for the school nurse and/or school personnel to administer the above-named medication to my child according to the healthcare provider's directions.
- I release CFCA and its employees from all liability that may result from my child taking their prescribed medication.

**RELEASE FOR STUDENT TO CARRY EMERGENCY MEDICATION**

Please complete if medication is for asthma, allergic anaphylaxis or diabetes management

**YES NO** Student may possess and self-administer asthma medication during the school year.

**YES NO** Student may possess and self-administer an EPI-Pen Auto Injector during the school year.

**YES NO** Student may possess and self-administer insulin and may carry diabetic management supplies during the school day.

**YES NO** The student has demonstrated and understands the correct administration of their medication. The student understands that they must not share the medication with other students. The student understands that the medication must be kept and put away in a safe location away from other students. In the event the student must use their emergency medication the clinic/nurse must be notified immediately for further observation and notification to parents of emergency medication usage.

**I herby release CFCA and its employees from al liability that may results from my child's taking their prescribed medication or injuries arising from a student's possession or self-administration.**

Parent Name: _____ Parent Signature: _____

Phone: _____ Date: _____

School Nurse Signature: _____ Date: _____

Physician Signature or Office Stamp: _____ Date: _____

medication return date: _____ pick-up person name: _____ school nurse initials: _____