# CHAMBERS PUBLIC SCHOOLS

P. O. BOX 218
CHAMBERS, NEBRASKA 68725

PHONE: 402-482-5233


## AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

### THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

| Name of Medication | Dosage | Route | Time of Day |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

Reason for Medication: _____

If given on as needed basis the length of time between doses._____

Inhalers: _____
**Indicate if student must carry on his/her person**

Student is capable of self-administration of medication _____ Yes _____ No

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

*I request and authorize that the above-named student be administered/provided the above-identified medication in accordance with the instructions indicated above from _____ to _____ (not to exceed the current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.*

_____ _____
**Physician Telephone Number** **Physician Name (Print)**

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, route, and time to be given.

*I request/authorize the school to give medication to my student in accordance to standard school policy. I understand that unlicensed staff may be assigned to provide medication to my student, and I accept ultimate responsibility for monitoring the effects of this medication.*

*Permission to carry inhaler ____Yes____No* *Permission to self-administer medication ____Yes____No*

_____ _____ *Phone #* _____ _____
*Date* *Parent/Guardian Caretaker Signature* *Home* *Work*