JACKSON COUNTY SCHOOLS

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

This form is to be completed and signed by a licensed prescriber and the parent/guardian at the beginning of each school year for any student taking medication. A separate order is required for each medication and orders are good for the current school year only. When any change in medication or dosage occurs a new form must be completed and a new pharmacy bottle with accurate dosage information must be provided. The physician order and the pharmacy label must contain the same information. Copies of this form must be maintained in the student's permanent record file, and with the school nurse or designee responsible for dispensing medication. A photograph of the student may be taken to ensure correct identification and medication administration.

Student Information

To be completed by parent. Please print.

Student's Name: _____ **Age:** _____ **Date of Birth:** _____

Parent's Name: _____ **Emergency Contact:** _____ **(phone)** _____

Address: _____ **Relationship:** _____

_____ **Emergency Contact:** _____ **(phone)** _____

Telephone: (home)_____**(work)**_____**(cell)**_____ **Relationship:** _____

Physician's Authorization for the Administration of Medication

Use a separate form for each medication.

Diagnosis: _____ **Reason for Medication Administration:** _____

Name of Medication: _____ **Expiration Date of Order:** _____

Dosage: _____ **Method/Route:** _____

Time(s) of Administration: _____ **Reason (specific symptoms):** _____

Duration of Time it is to be taken: _____

Intended Effect: _____

Side Effect(s) or Allergies: _____

Comments/Special Instructions: _____

Required documentation of self-administration of emergency medication (e.g., bronchodilator, Epi-pen):

____ Student must maintain medication on his/her person. ____ The student has been trained/is capable of self-administering the above medication. Restrictions (specify): _____

____ Student may self-administer insulin. ____ Requires supervision by school nurse. ____ Requires observation.

____ Parent acknowledges the exemption of school system liability for medications self-administered per this order.

____ **Rectal diazepam may be administered by personnel trained and designated by a certified school nurse.**

Name of Physician/Licensed Provider (please print)**:** _____

Physician's Address: _____ **Telephone:** ____-____-____

_____ **Fax Number:** _____

Physician's Signature: _____ **Date:** _____

I understand that, whenever possible, all medications should be given at home. I give permission for my child, as identified above, to take the listed medication at school according to county policy. I also understand and agree that the school nurse may talk with the clinician and/or his/her staff, as well as school personnel, regarding the student's condition and administration of this medication and its effects. I further understand that the school, county school board and its employees and agents are exempt from any liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of asthma medication by the student and agree to indemnify and hold harmless the school, the county board of education and its employees or guardians and agents against any claims arising from the self-administration of asthma medication. (Reference: WV Code §16-3-4).

A student with a diagnosed medical condition may meet the criteria set forth in Section 504 of the Americans with Disabilities Act. Please contact the principal or school nurse for more information or if you would like to schedule a meeting to discuss the student's eligibility for a Section 504 Accommodation Plan.

Parent Signature: _____ **Date:** _____