## **AUTHORIZATION FOR ADMINISTRATION OF MEDICATION**

| Section 1: Parent/Guardian completes<br>Student:   |  | Date of Birth:  |  |   |
|--|--|---|--|---|
| School:  |  | Grade:  |  |   |
| Parent/Guardian:   |  | Phone:  |  |   |
| Section 2: Physician completes for pre<br>medications are the only medications a<br>over-the-counter medications (7-12 gra<br>I hereby authorize and request you to  | allowed for self-carry/se<br>ades only and student n   | lf-administer. Pare   | nt/Guardian complete   |   |
| MEDICATION DOSA  | AGE TIME   | <u>DURATION</u>   | SELF-CARRY/SELF  | -ADMINISTER   |
| 1  |  |   | ☐ YES  | □ NO  |
| 2  |  |   | YES  |   |
| 3  |  |   | ☐ YES  | $\square$ NO  |
| Additional instructions:   |  |   |  |   |
| Diagnosis/medical reason for medicati<br>Allergies:  |  |   |  |   |
| Parent: Medication will be administered record kept by the school. This information Privacy Act (FERPA). I agree to coording safe delivery of medication to and from school year.  Pursuant to Iowa Code §280.16, the second   | ation is confidential exce<br>inate and work with scho<br>n school, and to make a  | ept as provided un<br>pol personnel and<br>rrangements for re   | der the Family Educa<br>prescriber when cond<br>emaining medication a                                      | tion Rights and<br>cerns arise, to ensure<br>at the end of the      |
| liability, except for gross negligence, a The signature of the parent/guardian of Pursuant to Iowa Code §148, §150, or advanced registered nurse practitioner or device) in the course of professional another state which, under Iowa law, name, medication name, dosage, and | s a result of any injury a<br>on this form is an acknow<br>§150A, a person licens<br>r, or other person licens<br>all practice in Iowa in acc<br>may legally prescribe dru | rising from self-ad<br>vledgement of the<br>ed under these ch<br>ed or registered to<br>ordance with lowa<br>ugs, provides writte | ministration of medica<br>same.<br>apters (physician, phy<br>distribute or dispense<br>Code §147.107, or a | ysician's assistant,<br>e a prescription drug<br>person licensed by |
| Physician/Parent Signature   | Print name   |   | Dat  | e   |
| Physician/Parent phone   | Physician fax  | (   |  |   |
| Parent/Guardian: If the medication   | on will be SELF-CARRY  | //SELF-ADMINIST   | ΓER (asthma/airwav   | constricting or   |
| Epipen) this requires a physician's student signature in Section 3.  |  |   |  |   |

- 1. I/we hereby authorize my student to self-carry and self-administer the above named medication(s) during school hours. I/we have read the student agreement and have reviewed this with my student (see Section 3).
- 2. I/we understand my student will carry this medication at school. I/we also understand my student is entirely responsible for the use of this medication and use of this medication will **not** be monitored by school personnel.

| mv student un   | nderstanding this  | s agreement. My student has sig  | gned the agreement in Section 3.  MEDICATION - STUDENT AGREEMENT   |
|---|--|--|--|
| ☐ Inhaler   | ☐ Epipen   | ☐ Over-The-Counter (OTC)   | Other:   |
| ☐ Us<br>☐ No<br>☐ Ke<br>☐ No<br>a<br>b  | se correct medic<br>tot allow anyone<br>eep my medication<br>tify the school r<br>. My symptom<br>. I suspect tha<br>. If I have any   | oing health provider's medication ation administration technique (college to use my medication. On with me in school and on field turse or school personnel if the for continue to get worse after taking the material amplitudes and allergic reaction to its lost or stolen while at school at the material techniques.  | correct time, correct route, correct dose).  I trips. collowing occurs: ing the medication. by medication.   |
| Student Signa   | ature  |  | Date   |
| 1 request that 1. I will infrequence frequence with respect to the second will represent the second | the aforementic immediately not immediately not ency, or duration permission for regard to the list school intends to ol. You may refer impact administration of an ency provide health and the stored in the Student required. Authorization accordance I will pick | ify the school of any change in the of administration. The School Nurse to consult with ed medication, medical condition to use the requested information to use to supply the requested persistration of medication to your child. The equire access to this information to prescription and/or over-the-courrovided a signed and dated authors in original, labeled container as nurse's office.  The enemedication as needed. In its renewed annually and when the information left at the end of the with 79 Fed. Reg. 53520, 53546) or Please dispose | seed below, be given to my student during school hours. The medication or physician's order, dosage change, this student's physician concerning any questions that arise in, or side effects of this medication. The provide for your child's health and safety needs while at sonal information/consent to exchange information and this hild per the physician's order. This may result in an information you provide will only be shared with staff in the to ensure your child's safety and school success. Inter medications: it is not administer medication or a dispensed or manufacturer's labeled container and will be the parent notifies the school that changes are necessary. The school year will be properly disposed of (in a) if prior arrangements are not made by the parent: |
|   | inter medication<br>ental permission   |  | dents by authorized school personnel on an as needed basis   |
| ☐ Tyler☐ Ibup   | nol (acetaminop<br>rofen<br>gh drops<br>icids (TUMs)   | hen) Topi<br>□ A<br>B  | ical:<br>Anti-itch/anti-inflammatory (i.e. hydrocortisone, Calagel,<br>Benadryl cream, etc.)<br>Antibiotic ointment (i.e. Bacitracin, Neosporin)   |
| Parent/Guard  | dian signature   |  | Date   |
| Approved  |  |  | 1  |

Grinnell-Newburg School District, Grinnell, IA