PARENTAL AUTHORIZATION TO ADMINISTER MEDICINE

TO: _____
(School)

I am the parent, guardian or legal custodian with legal custody of _____, a minor student attending this school. This student requires medication at intervals during the school day. **Skiatook schools do not give morning doses of medication. The student needs to take it before school. This is to prevent accidental overdoses and to reduce traffic in our busy offices in the morning. All medications must be picked up by an adult before 3pm on the last day of classes each school year or they will be destroyed.**

I hereby give my consent and authorize the school nurse, the secretaries, or other school personnel that have had medication administration training to administer:

_____ _____(name of drug), a non-prescription medication which I am hereby supplying you, in accordance label instructions or the written instructions of a physician which are attached hereto.

_____ _____(name of drug), a filled prescription medication which I am hereby supplying you, in accordance with the directions for the administration of the medicine listed on the label of the vial. **25 pill maximum at one time. It is the parent's responsibility to know the expiration date of medication.**

_____ _____(name of drug), a filled prescription medication which I am hereby supplying you, in accordance with the written instructions of the physician prescribing the medicine, which is attached hereto.

_____ I hereby give my consent and authorize my child to self medicate under the School District's Policy on the Administration of Medicine to Students. **A physician's order stating that the student is able to self administer medication is required.**

I understand that under state law the Board of Education, the School District, or employees of the School district shall not be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering the medicine I have hereby authorized. I understand that the School District, its agents and employees shall incur no liability for any adverse reaction or injury suffered by the student as a result of the self-administration of medication and/or using the specialized equipment.

I agree to abide by all of the terms of the School district's Policy on the Administration of Medicine to Students, a copy of which will be given to me on my request.

_____ _____
Date Signature

_____
Print Name
Parent with Legal Custody or Guardian

Medication Check In

Name:_____
Medication:_____

Date	Number	Initials	Date	Number	Initals