L'ANSE AREA SCHOOLS
AUTHORIZATION FOR <u>PRESCRIBED MEDICATION</u> OR TREATMENT

Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent/guardian and physician requests for the administration of necessary prescribed medication or treatment to students.

The L'Anse Area Schools Board Policy 5330 provides that administration of prescribed medication and treatments in school must be: on the basis of written permission by the parent, guardian, or adult student; must be done in compliance with a physician's written instructions; and must be done in the presence of authorized adults.

Medication **must be** in the original prescription container clearly labeled with the name of the student; name and CURRENT dosage of the medication; method of administration; time of day to be given; name of physician; date issued; and pharmacy name, address and phone number. **Medication labels must correspond with the written orders of the physician.**

<u>Parents are responsible for monitoring the need for refills at school. Be sure to make appointments with physician ahead of time. Parents are responsible for the safe delivery of the medication to the school office. Students may NOT transport medication to school, with the exception of approved asthma inhalers and emergency medications.</u>

THE FOLLOWING INFORMATION IS REQUIRED FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL.

STUDENT NAME: _____ GRADE: _____

DATE OF BIRTH: _____ SCHOOL: _____ TEACHER: _____

A. ___ I am requesting permission for my child named above to:
_____ use or receive prescribed medication _____receive prescribed treatment

NAME OF MEDICATION OR TREATMENT: _____
DOSAGE: _____ TIME TO BE GIVEN: _____
BEGINNING DATE: _____ENDING DATE: _____
PHYSICIAN: _____ PHYSICIAN PHONE: _____
SPECIAL INSTRUCTIONS (include any special storage requirements or side effects that need to be reported): _____

B. ___ ***(Please initial) I* authorize the school to release or obtain information about this medication or treatment with my child's prescribing physician and pharmacy.**

C. ___ I will assume responsibility for safe delivery of the medication to school.

D. ___ I understand that it is the responsibility of my child to report to the office for his/her medication or treatment.

E. ___ I will notify the school immediately if there is any change in the use of the medication or prescribed treatment.

F. ___ I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

By law, any unused, discarded or outdated medicine must be picked up by the parent or guardian within seven (7) days of notification by school authorities or the medication must be destroyed by school personnel.

SIGNATURE OF PARENT/GUARDIAN/ADULT STUDENT: _____

DATE: _____ PHONE HOME: _____ WORK: _____

Physician Signature: _____