



Kodiak Island Borough School District

Medication Authorization Form – Prescription Long Term (more than 4 weeks)

Insert Student Picture Here

STUDENT _____ GRADE _____

SCHOOL _____ BIRTHDATE _____

ALLERGIES (MEDICATIONS) _____

Note: Prescription Medication must be delivered by a parent or guardian in the original container indicating the following information: student name, dosage, healthcare provider, pharmacy, date issued, and prescription number.

PARENT STATEMENT: I request that the prescription medication listed below be given to my child named above.

- I understand that only current medications will be given at school.
- I understand that in the absence of the school nurse, other trained school staff may administer medication.
- I agree to defend and hold the school district employees harmless from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements.
- I give permission for the school nurse to contact the health care provider regarding this treatment.
- **I will notify the school immediately if the medication is changed and understand that the nurse may contact the health care provider or pharmacist regarding this medication.**
- **I understand that this medication will be destroyed unless picked up by the end of the last student school day of this year per federal DEA requirements.**

Parent/Guardian Signature _____ Date _____

Home phone _____ Work/Emergency Phone _____

Other medications your child is taking _____

HEALTHCARE PROVIDER STATEMENT: This medication is required during school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication. The above named child should receive prescribed medication for the following condition: _____

- Medication _____
- Prescribed daily dosage _____
- Time and dosage given at school _____
- Beginning date of medication _____ Ending Date _____
- Possible side effects _____
- Special instructions for administration _____

Healthcare Provider Signature _____ Date _____

Printed Name _____ Phone _____

Healthcare Provider Address _____

Healthcare Provider Email _____

School Nurse Signature _____ Date _____

Phone _____ Fax _____ Email _____