Kodiak Island Borough School District

Medication Authorization – Prescription Short Term (less 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 following prescription medication be given to my child named above for not more than 4 weeks.
- For this condition_____
- 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 will administer the 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 the year.***

Medication _____**Dose** _____ **Route**_____ **Time to be given**_____
Prescription # _____**Pharmacy** _____**Begin Date**_____**End Date**_____
Healthcare Provider _____ **Phone/Contact Info** _____
Storage instructions_____
Special instructions for administration_____
Possible Side Effects
_____

As parent/guardian of the above named student, I request that the Kodiak School District give medication to my child.

X_____
Parent/Guardian Signature

Date _____ **Phone** _____

X_____
School Nurse Signature

Phone _____ **Fax** _____