Forest City Regional School District

Authorization for Administration of Medication During School Hours

Child's Name _____ Age _____ Grade _____

Please check one of the following:

_____ My child is capable of self-administering the medication(s) listed below, under the supervision of the principal, his designee or the school nurse.

_____ My child is not capable of self-administering the medications(s) listed below. I Understand that the school nurse will admi8nister the medication on days when she is at my child's school. When she is not available, I or someone I designate will administer the medication(s).

I relieve the Forest City Regional School Board and its employees of liability for medication administration and supervision of self-administration.

The Forest City Regional School District will not assume responsibility for medication(s) that is/are lost, stolen or left at home.

Parent Signature _____ Date _____

Home Phone _____ Emergency Phone _____

Physician Authorization

This form must be completed whenever any medication must be given to a student during school hours in order to maintain sufficient health to remain in school. Medication must be packaged in the properly labeled pharmacy container. This form must accompany all medication(s) brought to school.

#1
Medication _____ Dose _____

Diagnosis _____ Time Schedule _____

Duration (days, weeks, school term) _____

Special Instructions/Conditions to Observe _____

#2
Medication _____ Dose _____

Diagnosis _____ Time Schedule _____

Duration (days, weeks, school term) _____

Special Instructions/Conditions to Observe _____

Physicians Signature _____ Date _____

Physicians Name Printed _____