School District of Crandon

MEDICAL AUTHORIZATION FORM

2024-2025

All portions of this medical authorization form must be completed before medication/procedure will be administered by school district personnel.

Student Name: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

School: _____ **Grade:** _____ **Teacher:** _____

Name of Medication: _____

Diagnosis for which medication is to be given: _____

Dose: _____ **Route of Administration** ☐ **Oral (by mouth)** ☐ **Topical** ☐ **Nasal** ☐ **Inhaled**

☐ **Injection** ☐ **Eye** ☐ **Ear** ☐ **Other** _____

Frequency/Time(s) to be given: _____ ☐ **a.m.** ☐ **p.m.**

Dates to be given at school: **Start Date:** _____ **End Date:** _____

Directions for administration: _____

Explain possible reactions/side effects: _____

The School District of Crandon has my written consent to administer this medication/procedure as indicated above per my request. I agree to hold the School District, its employees or agents who are acting on this request within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

- I will supply medication in its original, updated, properly labeled container (an extra bottle can be requested from the pharmacy).
- I will obtain a new physician's order and notify the school in writing of any changes.
- I authorize the school nurse to exchange information verbally or in writing with my student's physician regarding this medication/procedure or conditions for which it is prescribed.
- I understand that trained, non-medical school personnel will administer medication/procedure.
- I understanding that all medication should be delivered to the school and picked up from the school by parent/guardian/responsible adult unless the physician indicates self-carry/self-administer.
- For Middle/High School students - my student has been instructed, is capable of self-administration, and has my consent to self-carry INHALER or EPI PEN:
  - ☐ Yes ☐ No **(REQUIRES practitioner signature and authorization before valid.)**
- My signature indicates that I have fully read and understand the above information.

Parent/Guardian signature: _____ Date: _____

Home Phone Number: _____ Work Phone Number: _____

PHYSICIAN AUTHORIZATION

The physician whose signature follows hereby authorizes school personnel to administer medication/procedure during the school day as prescribed. I agree to accept communication regarding the student/medication/procedure and understand trained, non-medical school personnel will administer the medication/procedure.

Asthma Inhaler. This student has been instructed and is capable of self-administration and may carry inhaler: ☐ Yes ☐ No

Epi Pen: This student has been instructed and is capable of self-administration and may carry Epi Pen: ☐ Yes ☐ No

Name of Physician: _____ Physician's Phone #: _____

Clinic Name and Address: _____

_____

Physician's Signature: _____ Date: _____

Reviewed by: _____ Date: _____