Medication Administration Authorization for Rockford Public Schools

Student's Last Name | First Name | Date of Birth | School Building | Grade

TO BE COMPLETED BY AUTHORIZED HEALTHCARE PROVIDER:

Medication Name	Dose	Route	Time/Frequency	Reason

Precautions/Special Directions _____

☐ Yes
☐ No

For Over the Counter (OTC) in 6th-12 grade or Emergency Medication Only

Student has permission to possess the designated medication(s) above at school and to self - administer such medication with or without supervision of school personnel. The student has been instructed in and demonstrates an understanding of proper usage.

I understand that medication administration may be performed by an unlicensed designated school personnel under the training and supervision provided by the school nurse. The administration of medications to students during school hours should only be permitted when failure to do so would jeopardize the health of the student or interfere with their educational program**.** Any change in medication, dose, frequency, or route will require a new form to be completed.

_____ _____

Printed Name of Authorized Healthcare Provider | Phone Number

_____ _____

Signature of Authorized Healthcare Provider | Date

TO BE COMPLETED BY PARENT/GUARDIAN:

Per Rockford School Board Policy 5330, I am requesting permission for my child named above to use or receive the prescribed medication in accordance with the healthcare provider's direction. I assume responsibility for safe delivery of medication to school. I will notify the school immediately if there is any change in the use of medication. 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.

*I authorize the healthcare provider listed and school nurse to engage in verbal, electronic, or written communication in order to share records and information when necessary for the health and safety of the student listed above.

*If your child in Medicaid eligible, school health services may be billed on behalf of the school. School district billing will not impact future benefits of your family's Medicaid plan. Orders are valid through the end of the current school year.

☐ **Parent/Guardian Initial to Agree for student to Possess and Self-Administer Medication(s) - Over the Counter (OTC) in 6th-12th grade or Emergency Medication Only**

As per the healthcare provider's authorization above, I request and give permission for my child to possess and self-administer the above OTC or emergency medication(s) during the school day and school sponsored events. My child has been instructed in the treatment plan and demonstrates an understanding of proper usage and self-administration of the above listed medication(s). I understand that the privilege of carrying medication on campus may be revoked if the medication is used in a manner other than prescribed.

_____ _____

Printed Name of Parent/Guardian | Phone Number

_____ _____

Signature of Parent/Guardian | Date