5325 FORM 1 - Authorization for Medication

State guidelines and Utica Community Schools Board of Education Policy #5325 require that written permission from a parent/guardian and physician be on file in the school office before medication will be administered to a student. Prescription medication must be in its original container with the original pharmacy label attached. Non-prescription medication must be in its original container with student's name and dosage. **An adverse reaction to medication may result in an emergency call to 911 and to the student's parent/legal guardian.**

Student's Name ______________________________ Date of Birth _______________

Name of School ____

Grade/Homeroom/Teacher(s) ______________________________ Gender _________

Physician's Name ____

Physician's Address ____

Name of Medication ____

Reason/Diagnosis for Medication (optional) __________________________________

Form of Medication/Treatment:

___ tablet/capsule ___ liquid __ inhaler ___ injection ___ nebulizer ___other

INSTRUCTIONS:

Dose __________________ Time _______________ Daily Temporary As Needed

If medication is to be given "as needed," describe indications

____

How soon can medication dose be repeated? _____________________________________

Restrictions and/or important side effects

___ I request that my child be assisted by authorized school personnel in taking the described medication at school according to Board of Education Policy #5325

___ I request that my child be allowed to self-administer the above medication at school according to school policy. (Applicable to senior high school students only.)

___ This student is capable and responsible for carrying and self-administering ___Epinephrine ___ Inhaler
(A second epinephrine injection or inhaler must be stored in the school office)

___ I authorize school personnel to administer
______ Glucagon (CALL 911) ______ Epinephrine (CALL 911) __Other __________________

If, based on their observation, they believe a **life-threatening condition** exists. I hereby release Utica Community Schools and its personnel from any and all liability that may result from their determination that a life threatening condition exists.

Signature ______________________ Relationship _______________ Date __________

Physician's Signature ____ Date __________

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