

**ANNA JONESBORO HIGH SCHOOL DISTRICT 81
SCHOOL MEDICATION AUTHORIZATION FORM
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AND
SELF-ADMINISTRATION OF ASTHMA INHALER OR EPIPEN REQUEST FORM**

District policy states that medication may be given to students only upon the written request of the student's physician and parent.

All medication sent to school must be in the original package. Prescription medications must be in the labeled pharmacy container. The label must include: the student's name, physician, the name of the medication, dosage, and time to be given. Unclaimed medication at the end of the school year will be discarded.

This form must be completed and returned to the school nurse before the medication can be given and must be updated every school year.

TO BE COMPLETED BY THE DOCTOR:

Student's Name: _____ DOB _____

School Year: _____ Diagnosis: _____

Medication: _____

Dosage: _____ Time of administration: _____

Possible side effects: _____

Can the student self-carry/self-administer their asthma inhaler or EpiPen? Yes _____ No _____

Other medications student is receiving at home: _____

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize AJCHS District #81 and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A CERTIFIED SCHOOL NURSE AND CONSENT TO SUCH PRACTICES. I further acknowledge and agree that, when lawfully prescribed medication is administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Physician's Signature:

Parent/Guardian's Signature:

Date:

Print Name (parent/guardian)

Relationship to Student

Physician Phone: _____

Parent/Guardian Phone: _____