

University School

Authorization to Administer Medication-Emergency Medications

Medication shall be administered only when the student's health requires that it be given during school hours. It is the parent/guardian's responsibility to bring this medication to school and remove any unused medication when treatment is completed.

All prescription medication must be brought to school in the original container. The pharmacy label must include the following:

- Name of student
- Prescription number
- Name of medication and dosage
- Administration route or other directions
- Date
- Licensed prescriber's name
- Pharmacy name, address and phone number

All OTC or non-prescription medication must be brought in the original manufacturer's labeled container with the ingredients listed and the child's name affixed to the container.

No more than one month's supply of any medication should be brought to school.

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Parent/Guardian Authorization

Student's Name _____ DOB _____ Grade _____ Allergies _____

I request that school personnel administer the following medication to the above named student while in school and away from school for school activities.

Name of Medication: Insulin/Glucagon/Epi-Pen/Rescue Inhaler Amount to be taken: _____

Medication to be taken orally topically inhalation injection

Time to be taken while at school: _____ Date of last dose: _____

Reason medication is needed at school: _____

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. In consideration of the acceptance of the request to perform this service by any person employed by Washington County School System, the undersigned parent/guardian hereby agrees to release the Washington County School System and its personnel from any legal claim they now have or may thereafter have arising out of the administration of or failure to administer the medication to the student.

I will assume full responsibility for any side effects and complications that my child may have as a result of taking this medication.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____ Contact Number: _____