RESET FORM

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 (only FDA approved) must be in its original sealed container with the original pharmacy label attached. Non-prescription medication (only FDA approved) must be in its original sealed 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 (printed) _____

Physician's Address _____

Physician's Phone _____

Name of Medication _____

Reason/Diagnosis for Medication (optional) _____

Form of Medication/Treatment:

☐ tablet/capsule ☐ liquid ☐ inhaler ☐ injection ☐ nebulizer ☐ other

INSTRUCTIONS:

Dose _____ Time _____ Check One: ☐ 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 my child be assisted by authorized school personnel in taking the described medication at school according to Board of Education Policy #5325

☐ This student is capable and responsible for carrying and self-administering ☐ Epinephrine ☐ Inhaler

Students are not permitted to self-carry or self-administer oral medications. Exception to self-carry and self-administration guidelines MUST be approved by physician, district nurse, and building administrator on a case-by-case basis.

☐ I authorize school personnel to administer the following rescue (emergency) medication(s):

_____ Call 911

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 _____