

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 \_\_\_\_\_ Circle 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 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 \_\_\_\_\_