INDIAN TRAILS MUSTANGS
The Big 3!

INDIAN TRAILS MIDDLE SCHOOL

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AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION TO STUDENTS BY SCHOOL PERSONNEL

NOTE: SCHOOL BOARD POLICY REQUIRES THAT:

1. Prescription medication can only be administered at school when failure to take such medication could jeopardize a student's health.
2. Medication must be brought to school by the parent/guardian. It must be in the original container labeled by the pharmacy to include the following, and **must exactly match the doctor's orders:**
   a. **NAME OF STUDENT**
   b. **NAME OF DOCTOR (Licensed and authorized by state law to order prescription medication)**
   c. **NAME OF MEDICATION**
   d. **INSTRUCTION AS TO DOSAGE (amount and time)**
   e. **INDICATION OF SPECIAL STORAGE, IF NEEDED (refrigeration, etc.)**

DOCTOR'S AUTHORIZATION (To be completed by doctor)

_____ _____ _____
Student's Name School Date of Birth

The above student is under my medical supervision. I have ordered _____ doses of

_____
(Name of Medication)

to be administered at _____ am / pm.

Reason for medication to be administered at school: _____
Possible reaction or side effects: _____
Date this prescription expires: _____
Signature of Doctor: _____ Date: _____

_____
Address Telephone Number

PARENT / GUARDIAN PERMISSION

I hereby request that my child be given the above mediation while in school and away from school for school activities. I understand that law provides that there shall be no liability for civil damages as a result of the administration of such mediation where the person administering such medication acts as an ordinary reasonable prudent person should have acted under the same or similar circumstances.

Signature of Parent / Guardian: _____

_____ _____
Parent / Guardian Name Address

_____ _____ _____
Home Phone Number Emergency Phone Number Business Phone Number

_____ _____
School Nurse Signature / Authorized School Personnel Date

SCHOOL SHOULD RETAIN THIS FORM IN THE STUDENT'S CUMULATIVE HEALTH FOLDER