

Cherryvale-Thayer  
USD 447

**Authorization for Medications/Procedure to be Administered  
School, Field Trips, and Extracurricular  
Parent/Legal Guardian to Complete**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

Prescribing Physicians Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I grant permission for the school nurse or a delegated staff member to administer medications/treatment to my child at school as indicated by my child's physician accordingly below. I understand that I must provide any prescribed medication in its original labeled container.

I also acknowledge the need and give permission for appropriate communication between the school health professional and the medical prescriber related to the specific treatment in questions, including communication concerning: 1. The prescription or treatment itself (e.g. questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube); 2. Implementation of the treatment in school (e.g. questions regarding safety concerns, infection control issues, or medications in the treatment order related to the school setting or students' academic schedule); 3. Student outcomes from treatment (e.g. questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom); 4. And other pertinent issues related to the student's diagnosis, condition, or treatment.

I understand the policy of the Board of Education of USD 447 will keep individual record of each medication administered, any changes to prescribed medication (e.g. type of medication, dosage, and/or time of administration) should be accompanied by a new Authorization for Medications/Procedure to be Administered at School, Field Trips, and Extracurricular Activities form and a newly labeled container. In the administration of medication, the school employee shall not be deemed to have assumed any legal responsibility other than acting as a duly authorized employee of the school district.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Parent/Legal Guardian (Printed Name)

\_\_\_\_\_  
Date

**Physician to Complete**

Current Diagnosis(es): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**PHYSICIAN MEDICATION AND/OR TREATMENT ORDERS:** (please specify)

Medication/Treatment

Dosage

Time/Frequency

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician/Midlevel Signature

\_\_\_\_\_  
Physician/ Midlevel (Printed Name)

\_\_\_\_\_  
Date