Print Form

MEDICATION AUTHORIZATION

Mat-Su Borough School District
501 N. Gulkana
Palmer, AK 99645
P: (907) 746-9200

It is the policy of the Matanuska-Susitna Borough School District that medication may be dispensed in school only when the student's health requires that the medication be given during school hours. Medication to be dispensed at school must be in an original, properly labeled prescription bottle. **This form, or a written statement signed by the health care provider, is required for all medication prescribed for more than two weeks.** This form must be updated annually. All medication will be destroyed unless picked up by the end of the last student school day of this year.

School Nurse_____ **School**_____

Phone_____ **Fax**_____

Student:	**DOB:**	**Medication:**	**Dose:**	**Route:**
Time:	**Reason:**	**Side effects:**	**Special Instructions:**	**Start Date:** **Discontinue Date:**

_____ _____

Date **Health Care Provider Signature**

_____ _____

Phone and Fax Numbers **Health Care Provider Printed Name**

TO BE COMPLETED BY THE PARENT AND HEALTH CARE PROVIDER AND RETURNED TO THE SCHOOL NURSE BEFORE MEDICATION MAY BE ADMINISTERED.

I hereby give permission for my child to receive the above listed medication at school and/or during school sponsored activities, as prescribed by my child's health care provider. Permission is also given for the school nurse to contact the health care provider regarding this treatment.

I understand all medication will be administered by the school nurse or designated school employee in the absence of the school nurse. The school nurse will train the following staff. I delegate the staff members listed below the task of administering prescribed medication in the absence of a registered nurse.

STAFF MEMBERS TRAINED Name	Title	Location/Room #	Trained By

I agree to save, defend and hold harmless the Matanuska Susitna Borough School District, its employees, elected or appointed officials, from any liability or damages as a result of the administration of this medication or the effects of the medication. I agree to notify the school nurse immediately of any changes in medication dosage, adverse or ill effects from the medication, or discontinuance of the medication.

_____ _____

Date **Parent/Guardian Signature**