ORANGE SCHOOL DISTRICT
MEDICATION ADMINISTRATION RECORD
FOR THE AUTHORIZATION OF MEDICATION ADMINISTRATION AT SCHOOL

Since medication for the student listed below cannot be scheduled for other than school hours, it is requested that school personnel, who are adequately trained, supervise the administration of medication.

PHYSICIAN/PRESCRIBER AUTHORIZATION

Student Name _____ is under my

care for (diagnosis)_____

and should receive (name of medication/treatment) _____

dosage _____route _____ at the following time(s)_____

_____.

Specific side effects/severe reactions to watch for: _____.

Special instructions for administration: _____.

Date to begin medication: _____ Date to end medication: _____
(Expiration date of this request should not to exceed one school year)

Physician/Prescriber's Name (print): _____

Physician/Prescriber's Signature: _____

Physician/Prescriber's Phone number: _____

PARENT/GUARDIAN AUTHORIZATION AND RELEASE

We (I) the undersigned who are the parent(s)/guardian(s)/foster parent(s) of _____ request that the above medication or treatment be administered to our child in accordance with the instructions of our physician/prescriber_____. We (I) understand that trained school personnel may supervise the administration of said medication. Furthermore, we (I) understand that the school personnel are not legally obligated to administer medication to any child and, therefore, we (I) release and agree to hold the Board of Education and/or its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and harmless from any and all liability for damages or injury resulting directly from this authorization. Further, we (I) will notify the school in writing immediately if we change physicians, medication, change dosage, or terminate the use of this medication for any reason. We (I) will assume all responsibility for safe delivery of the medication to school and this delivery will be as specified in Policy 5330 of the Orange Board of Education. We (I) authorize the licensed healthcare professional to talk with the prescriber to clarify medication order.

Signature of Parent/Guardian: _____ Date: _____

#1 Contact Phone: _____ #2 Contact Phone: _____

Student Name: _____

Date of Birth: _____ Grade: _____