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

Since medication/treatment for the student listed below cannot be scheduled for other than school hours, it is requested that the school nurse or designated staff who has been trained by a registered nurse or licensed health care provider administer the medication/treatment.

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/treatment: __________________ Date to end: __________________

(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: __________________________