NEW PRAIRIE UNITED SCHOOL CORPORATION

NPUSC AUTHORIZATION FOR MEDICATION ADMINISTRATION

To the Parent: THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED OR NONPRESCRIBED MEDICATIONS IN SCHOOL.

_____ _____

Name of Student Date Initiated

_____ _____

School Grade

I am requesting permission for my child named above to be administered medication(s) by the school designee. I understand the following:

A. Prescription medication may only be given when the medication is in the **original container with the original pharmacy label.** Prescription infers physician/health care provider's order and approval. I will notify the school in writing immediately if there is any change in the use of the medication or dosage.

B. Over-the-counter medication may only be given according to the directions on the bottle. All medication must be in the original container, not expired, and labeled with the student's name.

C. I will assume responsibility for safe delivery of the medication to school. Medication, whether over-the-counter or prescribed, must be brought to school and kept in the original container. Medication(s) will be placed in the health office in a secure manner.

D. Consent to administer this medication during school hours is valid for the current school year only.

E. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

MEDICATION NAME	DOSAGE	ROUTE	TIME TO BE GIVEN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If your child has medication left at the end of the school year, please indicate what you would like done with the medication by checking the appropriate statement below. Medications not picked up at the end of the school year will be properly disposed of.

☐ I will pick up my child's medication.

☐ The following individual who is at least 18 years old will pick up the medication.
Individual's Name: _____

☐ The school has my permission to send non-controlled substances home with my middle school or high school child.

_____ _____

Signature of Parent/Guardian **Name of Physician/Health Care Provider**

NOTE: In order to carry and self-administer prescribed EMERGENCY medication(s), the Authorization for Emergency Medication Administration form must be completed.