

**Sandoval Community School District #501  
School Medication Authorization Form**

A written order for prescription and non-prescription medications must be obtained from the child's licensed prescriber. The order includes:

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_ **ALLERGIES** \_\_\_\_\_

Licensed Prescriber \_\_\_\_\_

Prescriber's Phone # \_\_\_\_\_ Emergency # \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Route of Administration \_\_\_\_\_

Frequency of Administration \_\_\_\_\_

Date of Prescription \_\_\_\_\_ Date of Order \_\_\_\_\_

Discontinuation \_\_\_\_\_

Diagnosis \_\_\_\_\_

Intended Effect of Medication \_\_\_\_\_

Other Medication Child is Receiving \_\_\_\_\_

Time Interval for Reevaluation \_\_\_\_\_

Possible Adverse Effects of this Medication \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Sandoval School District 501 and its employees and agents, in my behalf and stead, to administer or attempt to administer to my child (or let my child self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless the indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Please sign below to request the above medication be given at school. Medication must be brought to school in a container appropriately labeled by the pharmacy or physician, and non-prescription medications ordered by the physician should be brought with the original label and the child's name affixed to the container.

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Emergency Phone #