JEFF TECH

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Prescription Medication Administration Authorization

Student Information

- Full Name: _____ DOB: _____
- Shop: _____ Grade: _____

Parent/Guardian Authorization & Waiver

I, the parent/guardian of the above-named student, request and authorize the school nurse or trained school personnel to administer the medication as per physician order. I agree with the following:

1. **Supply:** I will provide the school nurse with a physician order. I will provide the school nurse with the medication in its original pharmacy-labeled container.
2. **Updates:** I will notify the school in writing immediately of any changes to the prescription.
3. **Communication:** I authorize the school nurse to communicate with the prescribing practitioner for any necessary clarification regarding this order.
4. **Self-Administration (Epi-pens & Inhalers ONLY):** I grant permission for my student to carry and self-administer an Epi-Pen and Inhaler if determined safe by the school nurse and practitioner (initial if applicable: _____).
5. **Liability:** I release the school district and its employees from all liability that may result from the administration of this medication in accordance with this authorization.

Additional Requirements

- **Self-Carry Rules:** High school students **may** carry **emergency medications** (like Inhalers or EpiPens). Students must sign the competency paper in the nurse's office, a health care plan must be on file, and a physician order is still required.
- **Delivery:** Parents are responsible for delivering medications directly to the school office. **IF** there are unforeseen circumstances please contact the nurse's office.
- **Disposal:** Medications must be picked up by the student's parent by the end of the school year. Failure to do so will result in the disposal of the medication.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____

THE SCHOOL OF CHOICE
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