BALTIC SCHOOL DISTRICT 49-1

REQUEST AND AUTHORIZATION FOR MEDICATION

Name of Student _____ Birthdate _____/_____/_____ Grade _____

Address _____ Home Phone _____

Father/Guardian Cell Phone _____ Relationship to Student _____

Father/Guardian Email _____

Mother/Guardian Cell Phone _____ Relationship to Student _____

Mother/Guardian Email _____

WE ENCOURAGE MEDICATIONS/TREATMENTS TO BE TAKEN OUTSIDE OF SCHOOL HOURS IF POSSIBLE.

1.) Diagnosis _____
2.) Name of Medication/Treatment _____
3.) Amount and Time(s) to be Administered at School _____
4.) Method of Administration _____
5.) Duration (week, month) _____
6.) Precaution and Reactions to Observe and Report _____
_____
_____

Physician's Signature _____ Phone _____ Date _____

<u>REQUIRES RENEWAL AT THE BEGINNING OF EACH SCHOOL YEAR.</u> Changes may be called to the school nurse by the physician and written information following within 24 hours. Faxes are acceptable. Fax 605-529-5443.

I _____, request and authorize personnel at the above named school to supervise the medication/treatment prescribed on this form to my child. I understand the medication must be provided in a bottle identifying the name and telephone number of the pharmacy, the students name, physicians name and dosage of the drug to be taken. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. In addition, I understand that I am responsible to pick up unused medication on or before the last day of school or one week after the last dose is given. If mediation is not picked up, it will be destroyed.

Parent/Guardian Signature _____ Dated _____