## **Student Medication Authorization Form**

(Required when a student needs prescription and non-prescription medication to be taken at school.)

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Student's Name	Birth Date	School	Date	
<ul> <li>Physician/prescriber signed</li> <li>Parent/guardian signed an</li> <li>Medication must be in ori</li> <li>Medication label must con</li> </ul>	ed and dated authorization ad dated authorization to a ginal labeled container as ntain student's name, nam	ministered following these guideline to administer the medication dminister the medication dispensed or the manufacturer's labeled e of the medication and directions for u ification of changes are required.	d container	
Medication/Treatment	Dosage	Time to be a	dministered	
Intended Effect of Medication/Treatment		Side Effects (if any)	Side Effects (if any)	
Other Medication the Stude May student self-administe Administration Instructions	r medication under supe	ervision of a school designee?	Yes orNo	
Date to Discontinue, Reeva	luate or Follow Up:			

## Parent Authorization:

I acknowledge that I am primarily responsible for administering medication to my child. In the event that I am unable to do so or in the event of a medical emergency, I authorize my child to self-administer while under the supervision of an employee or agent of Kalamazoo RESA, Education for the Arts and/or Education for Employment, lawfully prescribed medication in the manner described above. I further acknowledge and agree that when lawfully-prescribed medication is so administered or attempted to be administered, I waive any claims that I might have against Kalamazoo RESA, Education for the Arts and/or Education for the Arts and/or Education for Employment, host School Districts, their employees and/or agents arising out of the administration of said medication.

arent's Signature	Date Sign
arent's Phone Number mergency Phone Number	Parent's
dditional Information:	