INDEPENDENT SCHOOL DISTRICT OF BOISE CITY
AUTHORIZATION FOR MEDICATION ADMINISTRATION

To be completed by parent/guardian:

Student's Name:______________________________________Grade:_______ Date:______________

Birth Date:____School:_________________________

Parents' Names Father:_________________________Mother:_________________________

Guardian:_________________________________

Telephone Home:___________________Emergency Contact:______________________

Father's Work:________________________________Mother's Work:_________________________

Physician:____________________________________Hospital:______________________________

When requested by a physician or a parent, during school hours, a nurse or designated individual may assist with medication administration to students, with the licensed professional nurse's guidance. The licensed professional nurse is the only staff member who is qualified to supervise the assistance of medication administration in the school. This form must be completed and signed by the school nurse and the parent or guardian.

For the safety of all students, it will be the responsibility of the parent/guardian to transport medication. Exceptions can be made in rare cases. All medication should be brought in a prescription labeled bottle or a manufacture's labeled bottle with directions for use.

This release form authorizes the school nurse to follow the parent's request according to the original label or physician's orders and communicate with the doctor as needed. The Boise School District cannot assume any liability for consequences, which arise as a result of following the manufacture's label or doctor's orders. A parent is encouraged to administer the first dose of medication, prior to attending school to observe any potential signs of reaction. Please sign and return to the school office.

______________________________________ ______________________________________
Parent's/Guardian Signature Date

______________________________________ ______________________________________
Principal (optional) Nurse

To be completed by nurse or designated health service staff:

Name of Medication:____

Dosage and directions: (Copy from Label)

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3/12/04
06/07