**AUTHORIZATION/PARENTAL CONSENT**
**FOR SCHOOL TO PROVIDE MEDICATION**

*NOTE: Use a separate authorization form for each medication. Provide the school with a new form each school year, each time the student has a new medication, and each time there is a change in the student's current medication regimen.*

Student's last name: _____

Student's first name: _____

Gender: _____ Grade: _____ Date of birth: _____/_____/_____

**EMERGENCY CONTACT INFORMATION**

Parent/guardian's emergency contact name and number:

_____ ☐Home ☐Work ☐Cell

Parent/guardian's emergency email address:

_____

Alternate family member's emergency contact name and number:

_____ ☐Home ☐Work ☐Cell

Relationship to student: _____

Primary healthcare provider's name and phone number:

_____

Secondary healthcare provider's name and phone number (if applicable):

_____

Student's pharmacy name and phone number:

_____

**STUDENT HEALTH INFORMATION**

Does the student have any known allergies? ☐Yes ☐No
*If yes, attach a list of known allergies to this form and certification from a healthcare provider that the student is not known to be allergic to any medication the school is requested to provide or any medication that the student will self-administer.*

Does the student have knowledge of his/her known allergies and has been educated on the signs and symptoms of allergic reactions and how to prevent them? ☐Yes ☐No

Does the student have any medical conditions the school should be aware of? ☐Yes ☐No

If yes, describe: _____

Will the student be taking more than one medication at school or while otherwise under the school's supervision? ☐ Yes ☐ No
*If yes, attach certification from a healthcare provider that the medications are not known to adversely interact or information on how to avoid any known adverse interactions.*

**MEDICATION AUTHORIZATION**

Name of Medication:_____

Serious reactions/adverse side effects from this medication may occur: ☐Yes ☐No

If yes, describe:_____

_____

Action/treatment for reactions: _____

_____

Special handling instructions: ☐Refrigeration ☐Keep out of sunlight

☐Other: _____

Is any dispensing equipment or other medical equipment required in order for the student to receive medication? ☐Yes ☐No

If yes, describe equipment and any special storage instructions: _____

_____

**PARENTAL CONSENT**

I am the parent or guardian of _____. I give my permission for him/her to take the following medication while in the North Border School District.

I acknowledge that I have read, understand, and agree to comply with the school district's medication program policy. I certify that the information included on this form is accurate to the best of my knowledge. I hereby release the North Border School District and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

_____ _____

Parent/Guardian Signature Date

**STUDENT CONSENT**

I acknowledge that I have read, understand, and agree to comply with the school district's medication program policy. I also acknowledge and agree to comply with the district's drug and alcohol free school policy, which contains restrictions related to medication, including rules prohibiting me from giving medication (prescription and over-the-counter) to other students.

Anytime I believe that I am having a reaction to my medication, I will report this information to my teacher or another school employee. If I have received permission to carry medication, I agree that I will not leave the medication unattended or unsecured and accessible to other students.

_____ _____

Student Signature Date