PARENTAL AUTHORIZATION, RELEASE AND RECORD FOR THE ADMINISTRATION OF AS NEEDED PRESCRIPTIONS AND NON-PRESCRIPTION MEDICATION TO THE STUDENTS OF
NORTH SCOTT SCHOOL DISTRICT

NAME OF STUDENT _____

SCHOOL _____ GRADE _____

MEDICATION _____

DOSAGE _____ TIME _____

REASON FOR MEDICATION _____

DATE TO BEGIN _____ DATE TO END _____

POSSIBLE ADVERSE REATIONS, UNUSUAL CIRCUMSTANCES, ACTIONS, OMISSIONS, OR SPECIAL INSTRUCTIONS
_____
_____
_____

I hereby request the North Scott Community School District, or its authorized representative to administer the above named medication to my child named above and agree to:

1. Submit this request to the school nurse or principal.
2. Personally ensure that the medication received by the school nurse, principal, or designee administering designee is in the container in which it was dispensed by the prescribing physician or licensed pharmacist. Non-prescription medication must be in the original package.
3. Personally ensure that the container in which the medication is dispensed is marked with the medication name, dosage, interval and expiration date.
4. Personally ensure that at vacation time, end of the school year, or the end of the administration time, the medication will be picked up or it will be destroyed.
5. Submit a REVISED STATEMENT signed by the physician prescribing the medication to the school nurse or principal IF ANY INFORMATION PROVIDED BY THE PHYSICIAN CHANGES.

Parent/Guardian _____ Date _____
Physician's Signature (if necessary) _____ Date _____

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

Signature	Date	Signature	Date