PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION OF MEDICATION TO STUDENTS

Student Name:_____ Grade:_____

Date:_____ Schoo:_____ Date of Birth:_____

It is necessary that this student receive the following medication:

_____

(Name of medication) (Dosage) (Time)

Beginning on _____ and continuing through _____.

Confidential Release of Information Consent

I hereby request the Muscatine School District, or its authorized representative, to administer the above-named medication to my child name above. I also authorize, as needed, the sharing of information relating to my child's health, (student's name)_____ between the school nurse (or designee) and the health care provider, Dr. _____. I will also comply with the procedure listed below for the dispensing of medication at school.

1. Submit this authorization form to the principal or school nurse.

2. Prescription drugs must be provided by the parent or legal guardian and must come in the original container which is marked with medication name, dosage, interval dosage and date after which no administration should be given.

3. Over-the-counter medications are discouraged during school hours. If it is necessary, over-the-counter medications must come in the original container and include written permission and instructions from the parent or guardian.

4. No medications will be provided by the school.

5. Submit a revised authorization form to the principal, school nurse, or designee when medication, dosage or instructions change.

DESIGNATED CARE PROVIDER:

Dr. _____ Agency:_____ Phone:_____

Address_____ City:_____State:_____

Parent/Legal Guardian Signature_____Date:_____
Relationship to Student:_____ Daytime Phone_____
Alternate Daytime Phone:_____

Approved: 03-28-05 Reviewed: 10-11-10 Revised: _____