

**Basin School District #72**  
**Authorization of Medication**  
**For a Student At School**

**Please Check ✓:** \*Prescription \_\_\_\_\_ Non-Prescription \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME OF STUDENT \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

In order to keep this child in optimum health and to help maintain maximum school performance, it is necessary that medication be given during school hours. No injectables will be accepted at the school with the exception of bee sting self-injector kits. Please fill out the front of this form completely specifying 'NA' if not applicable to your student. We will use the back to document each dose given,

Medication \_\_\_\_\_

Check one: tablet \_\_\_\_\_ capsule \_\_\_\_\_ liquid \_\_\_\_\_ ointment \_\_\_\_\_ inhaler \_\_\_\_\_

Dosage:

Amount to be given \_\_\_\_\_ When to be given \_\_\_\_\_

Relationship to meals (if any) \_\_\_\_\_

Side effects (expected or predictable) \_\_\_\_\_

\*Prescribing Physician's Name \_\_\_\_\_

Phone Number \_\_\_\_\_

**PARENT'S PERMISSION**

I hereby give permission for my child, \_\_\_\_\_, to receive the medication specified above during school hours. Each time the student presents to the office to receive the medication it will be logged in the Medication Log Book located with the medications in a locked cabinet. If it is a daily regimen, please encourage your student to remember to come to the office for his/her medication, at the proper time.

I release the Basin School District #72 and their agents and employees from any and all liability that may result from my child taking this medication.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Day Phone

\_\_\_\_\_  
Date


