Authorization for Medication
Ridgway Area School District
School Year _____

FSG Elementary Fax – 814-776-4297
Middle – High School Fax – 814-776-4247

It is a policy of the Ridgway Area School District to administer prescribed medication during school hours only when absolutely necessary. If your child must receive medication during school hours, **the parent/guardian** must provide the school nurse with a *Medication Authorization* form signed by the student's parent/guardian and a *Medication Order* from a licensed prescriber. **All medications must be in an original package from the pharmacy. Medication orders are required for both prescription and over-the-counter medications. All medication and *Medication Orders* must be delivered to the school by the parent/guardian.**

Any unused medication must be picked up by the parent/guardian or designated adult. Any medication not picked up by the end of the last student day of the school year will be discarded.

Parent/Guardian Authorization/Consent (to be completed by parent/guardian)

I give my permission for my child, _____, to receive the following medication ordered by a licensed prescriber during the school day. I hereby release the Ridgway Area School District and all its employees from any and all liability for damages my child may suffer as a result of this request. I authorize the school nurse to communicate with the physician and/or pharmacy when necessary. I understand and agree that this form will be shared with staff members and transportation personnel to whom my child is assigned.

Parent/Guardian signature _____ Date _____

For self-administration/self-carry of asthma inhalers and epipens: I request that my child be permitted to carry and self-administer their inhaler/epipen. I understand that the school entity bears no responsibility for ensuring that this medication is taken.

Parent/Guardian signature _____ Date _____

Licensed Prescriber Medication Order (to be completed by Physician)

Student's Name _____ D.O.B _____

Medication	Dosage/strength	Frequency/Time	Route	Reason for medication

Possible Side Effects/Contraindications_____

Discontinuation Date _____ Allergies _____

Other medications (prescription or over-the-counter) student is taking _____

Field Trip (Daily medication only). Medications may be held for field trip: ____Yes ____ No

Early Dismissal Days: Administer _____ Omit _____

Delayed Opening Days: Administer at usual time _____ Administer at alternate time of _____

Is this child authorized to carry and self-medicate with asthma and /or anaphylaxis medication?
_____ Yes _____ No (Inhaler and/or Epipen)

I have trained this student in the proper administration and frequency of use. ____ Yes _____No

Licensed Provider signature_____ Date _____

Licensed Provider Printed Name _____Provider's Phone Number _____