Kimberly School District
141 Center Street West ▪ Kimberly Idaho 83341 ▪ Phone: (208) 423-4170 ▪ Fax: (208) 423-6155

Physician's Authorization for Prescription Medication Given in School

Note to parent or guardian:
The provision of medication to students during school hours is discouraged. However, our school recognizes those special cases where the student's physician documents a need for in-school dosing.

1. It is the policy of our school district to maintain a signed order for *each* medication that school personnel is to dispense during school hours. **This form must be completed, signed, and returned to your child's school before any medications are be given**.
2. This form must be renewed each school year.
3. The medication must be in its ***original*** **container**.

Student's Name: _____ Date of Birth: _____

School: _____Grade:_____ Teacher: _____

To be completed by the physician or authorized prescriber

Diagnosis: _____

Name of medication: _____
Form of medication/treatment:
☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other_____

Instructions (schedule and dose at school): _____
_____

Possible Side Effects: _____

Storage requirements: ☐ None, store at room temperature ☐ Refrigerate

Answer ***only*** if student in a Middle School or High School Student

Is this student is both capable and responsible for self-administering this medication?
☐ No ☐ Yes, supervised ☐ Yes, unsupervised

Due to the need for the immediate access by this student, this medication should:
☐ Be kept in the student's classroom ☐ Be kept in the school office ☐ Be kept in the students desk

Physician's Name: _____

Physician's Signature: _____ Date: _____

Address: _____Phone number: _____

To be completed by the parent/guardian

I give permission for my child to receive the above medication at school according to school policy.

Date: _____ Signature: _____ Relationship: _____