RIVERDALE SCHOOL DISTRICT
Sara Droessler, BSN, RN - School Nurse
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AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

Name of Student:_____ Phone:_____

Parent:_____ Address:_____

School:_____ Grade:_____ Teacher:_____

To be completed by Medical Doctor:

Medication and Dosage:_____

Time of day to be given:_____ Method of Administration:_____

Reason for Medication:_____ Duration:_____

NOTE: Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state.)

_____

_____

_____

_____ _____

Physician's Signature Date

_____ _____

Address/Clinic Phone Number - Clinic

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To be completed by the Parent:

The medicine is to be provided by the Parent and is to be in the original prescription bottle, labeled with the name of the medicine, dosage, time of day to be given, and the expected duration. The physician's name must be on the label.

I hereby give the Riverdale School District permission to give the above-named medicine to my child according to the directions stated by my child's physician.

I also give Riverdale School District and the above-named Physician permission to exchange information concerning the administration of this medication and health information which pertains to reason for medication administration.

I agree to notify the school in writing when any change affecting the administration of the medicine is necessary.

I further agree to hold the school and its employees harmless in any and all claims which may arise from the administration of this medication at school.

_____ _____

Parent or Guardian Signature Date