

# DALLAS CENTER-GRIMES SCHOOL DISTRICT

Authorization to Administer medication at school



Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Teacher's Name \_\_\_\_\_ Building \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Time to be given \_\_\_\_\_ a.m. Time to be given \_\_\_\_\_ p.m.

Date from \_\_\_\_\_ to \_\_\_\_\_

Medication will be dispensed in accordance with the Code of Iowa and the 1985 Iowa Board of Nursing Declaratory.

**PRESCRIPTION:** The medication must come with written permission from the parent and in the original container, labeled with:

1. Name of pupil
2. Name of medication
3. Directions for use
4. Name of physician
5. Name and address of pharmacy
6. Date of prescription

**OVER-THE-COUNTER:** The medication must come with written permission from the parent and in the original container.

I request the above student be given the above medication at school and school activities by qualified staff (this includes all field trips), according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment or it will be properly destroyed.

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Address Home phone Work phone

Additional information: \_\_\_\_\_

\_\_\_\_\_