Ketchikan Gateway Borough School District
Authorization of **Over the Counter Medication** at School

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I will provide the school with the following medications for the above named student only. I give authorization for school personnel to administer the listed medications to my child. Only 1 dose to be given per school day. Parent will be notified if more than one dose is requested by student.

Medication from home	**Dosage**	**Directions**

Reason for Medication: _____

Possible Side effects of Medication: _____

Procedure in case of Emergency due to side effects: _____

_____

THIS AUTHORIZATION IS VALID FROM _____(date) to _____(date) not to exceed the current school year.

I request/authorize the school named above to administer medication to the above named student in accordance with the over-the-counter medication package instructions. The medication must be in the original package container. I understand that the school is not legally obligated to administer medication to my child. I hereby release the District from all claims, liability and expense, whether caused in whole or in part by the District, its employees or agents, which may in any way, arise out of or result from the administration or storage of medications including, but not limited to, claims for property damage and personal injury, including death. I further agree to defend and hold harmless the District, its employees and agents from and against any and all liability and expense which may in any way arise out of or result from the administration or the storage of medications.

Signature: _____ Date: _____

TO BE COMPLETED BY SCHOOL PERSONNEL

Authorization is hereby accepted by Ketchikan Gateway Borough School District. The above named medications ☐ are ☐ are not stored at the school.

Signature/Title: _____ Date: _____

Printed Name and Title:

_____

☐ Copy of School Board Policy given to parent/guardian.

Ketchikan Gateway Borough School District
Authorization of Prescribed and/or Emergency Medication at School

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP).

Medication	Dosage	Directions

Reason for Medication: _____
Possible Side effects of Medication: _____
Procedure in case of Emergency due to side effects:
_____
I authorize and request the above named student be administered the above identified medication in accordance with the instructions indicated above as there exists a valid health reason which makes the administration of the medication advisable during school hours.
THIS AUTHORIZATION IS VALID FROM _____(date) to _____(date) not to exceed the current school year.
Student has been instructed and is capable of self-administration of asthma and/or anaphalaxis medication: ☐ Yes ☐ No

LHP signature: _____ Date: _____
LHP printed name: _____ Phone: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN.

I request/authorize the school named above to administer medication to the above named student in accordance with the Licensed Health Professional's instructions.
I understand that every effort will be made by school staff to administer the medication in a timely manner.
If the Physician and School Nurse gives permission to self carry inhaler or self-administer medication: Do you give authorization for your child to: Carry and administer inhaler and/or anaphylaxis medication? ☐ Yes ☐ No
Signature: _____ Date: _____

TO BE COMPLETED BY SCHOOL PERSONNEL.

Authorization is hereby accepted by Ketchikan Gateway Borough School District. The above named medications ☐ are ☐ are not stored at the school.
Signature: _____ Date: _____

Printed Name and Title: _____
☐ Copy of School Board Policy given to parent/guardian.