



# Bismarck Public Schools

## MEDICATION ADMINISTRATION AUTHORIZATION: PRESCHOOL / ELEMENTARY SCHOOLS

**Directions for Parent:** Please complete this form if you want **BPS staff to administer prescription and non-prescription medications to your child. (Exception: reliever inhalers and Epipens).** (1) One of these forms **must** accompany **each** medication to be administered; (2) One of these forms **must** accompany each **new** medication or **change** in dosage that may occur during the school year; and (3) All types of medications must be in their **original containers**. We ask that **you** deliver your child's medication to designated school personnel (rather than your child).

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ School/Gr: \_\_\_\_\_ Teacher: \_\_\_\_\_

### INFORMATION ABOUT MEDICATION (Please print):

Medication Name/Strength: \_\_\_\_\_ How Many: \_\_\_\_\_ Time to Give @ School: \_\_\_\_\_

Route (Circle One: By Mouth Inhaled/Nasal Apply to Skin Apply to Eyes Drop into Ears Other: \_\_\_\_\_)

Reason for Medication: \_\_\_\_\_ Continue Until: \_\_\_\_\_

Instructions for Use: \_\_\_\_\_

Major Side Effects: \_\_\_\_\_

Other Information Staff Should Know About Student and this Medication: \_\_\_\_\_

Health Care Provider to Contact if Concerns/Emergency: \_\_\_\_\_ Ph #: \_\_\_\_\_

### AUTHORIZATION:

- I give permission to Bismarck Public School personnel, and medical personnel contracted by the School District, to administer this medication. I understand that administration of this medication will not necessarily be done by a nurse.
- I will notify the school immediately if my child's health status changes, or this medication is discontinued.
- I give permission to School personnel and contracted medical staff to contact the physician as needed; and that medication/health information may be shared with staff who need to know.

**I have read and understand the "Directions" and "Authorization" sections listed above (circle one): YES NO**

**I authorize school personnel (and medical personnel contracted by the District) to administer this medication to my child (circle one): YES NO**

Parent \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

*NOTE: This Authorization shall remain in effect for one school year (including summer school programs after the school year). Please note that new "Authorization" forms must be completed prior to the start of each new school year*

