

**DICKINSON PUBLIC SCHOOLS  
PRESCRIPTION AND AUTHORIZATION  
FOR MEDICATION ADMINISTRATION**

Complete this form when the student's physician and parent determine that medication must be taken during school hours.

Student: \_\_\_\_\_ School: \_\_\_\_\_  
School Year: \_\_\_\_\_ Date: \_\_\_\_\_  
Responsible Staff Person: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Medication: \_\_\_\_\_ Dose: \_\_\_\_\_  
Time/Frequency: \_\_\_\_\_ Continue Until: \_\_\_\_\_  
Reason for Medication: \_\_\_\_\_  
Special Instructions: \_\_\_\_\_

Possible side effects on learning and physical functioning: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Phone: \_\_\_\_\_ Address: \_\_\_\_\_

I request this medication be given to my child in the manner specified above. I give permission to school personnel to administer the medication. I understand that the administration of the medication will **not** be given by a nurse. I will notify the school immediately if my child's health status changes or there is a change or cancellation of this medication.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the School Board, the individual members thereof and any officials or employees involved in the administration of medications to the above named student from any claims or liabilities for injury or damages, including but **not** limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described medication.

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
Phone: \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_