Kenai Peninsula Borough School District Health Services

MEDICATION AUTHORIZATION FORM – Long Term Medication (page 1 of 2) **E5141.21(c-1)**

STUDENT _____ **GRADE** _____

SCHOOL _____ **BIRTHDATE** _____

Student Photo Here

Note: Prescription Medication must be in the original container indicating the following information: student name, dosage, healthcare provider, pharmacy, date issued, and prescription number.

PARENT STATEMENT: I request that the prescription medication listed below be given to my child named above.

- I understand that only current medications will be given at school.
- I understand that in the absence of the school nurse, other trained school staff may administer medication.
- I agree to defend and hold the school district employees harmless from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements.
- I give permission for the school nurse to contact the health care provider regarding this treatment.
- **I will notify the school immediately if the medication is changed and understand that the nurse may contact the health care provider or pharmacist regarding this medication.**
- ***I understand that this medication will be destroyed unless picked up by the end of the last student school day of this year per federal DEA requirements.***

Parent/Guardian Signature _____ ***Date*** _____

Home phone _____ ***Work/Emergency Phone*** _____

Other medications your child is taking _____

HEALTHCARE PROVIDER STATEMENT: This medication is required during school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication. The above named child should receive prescribed medication for the following condition: _____

- **Medication** _____
- **Prescribed daily dosage** _____
- **Time and dosage given at school** _____
- **Beginning date of medication** _____ **Ending Date** _____
- **Possible side effects** _____
- **Special instructions for administration** _____

Healthcare Provider Signature _____ ***Date*** _____

Printed Name _____ ***Phone*** _____

Healthcare Provider Address _____

☐Approved or ☐Denied School Nurse Signature _____ **Date** _____

School Administrator Signature _____ **Date** _____

Revised 4/13

Kenai Peninsula Borough School District Health Services

MEDICATION AUTHORIZATION FORM – Long Term Medication (page 2 of 2) **E 5141.21 (c-2)**

STUDENT _____ **GRADE** _____ **BIRTHDATE** _____ **SCHOOL** _____

Initials	Signature	Date, Amount of Med, Count Verified (Initials)					Date, Amount of Med, Count Verified (Initials)				Date, # In-coming Med	Date, # In-coming Med	Date, # In-coming Med	Date, # In-coming Med
			Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4				
		Aug					Jan							
		Sept					Feb							
		Oct					March							
		Nov					April							
		Dec					May							

MEDICATION _____ **DOSE** _____ **/ TIME** _____

Month_____		Month_____		Month_____		Month_____		Month_____		Month_____		Month_____		Month_____		Month_____	
Day	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**
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2		2		2		2		2		2		2		2		2	
3		3		3		3		3		3		3		3		3	
4		4		4		4		4		4		4		4		4	
5		5		5		5		5		5		5		5		5	
6		6		6		6		6		6		6		6		6	
7		7		7		7		7		7		7		7		7	
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30		30		30		30		30		30		30		30		30	
31		31		31		31		31		31		31		31		31	

Revised 4/13