Huron Academy
STRONG CHARACTER•STRONG EDUCATION•STRONG COMMUNITY

AUTHORIZATION FOR MEDICATION

State guidelines require that written permission from a parent/guardian be on file in the school office before medication will be administered to a student. Prescription medication must be in its original container with the original pharmacy label attached. In an emergency a call is made to 911 and to the student's parent/legal guardian.

Student Name: _____ Date of Birth:_____
Grade: _____ Teacher: _____
Physician Name: _____ Phone Number: _____
Physician Address: _____

Name of Medication: _____
(Optional) Reason/Diagnosis for Medicine: _____
Form of Medication/Treatment:
_____ Tablet/Capsule _____ Liquid _____ Inhaler ____ Injection ____ Nebulizer ____ Other

INSTRUCTIONS;
Dose: _____ Time: _____
Duration: _____ Daily _____Temporary _____As Needed

If medication is to be given "as needed", the doctor must describe indications:
How soon can medication dose be repeated? _____
Restrictions and/or important side effects: _____

_____ I request that my child be assisted by authorized school personnel in taking the desired medication at school according to Huron Academy School Policy.

_____ I request that my child be allowed to self-administer the above medication according to school policy.

_____ This student is capable and responsible for self-administering _____ Inhaler
(2nd grade and up can administer themselves with parental permission.)

If, based on their observation, they believe that a life-threatening condition exists, I hereby release Huron Academy and its personnel from any and all liability that may result from their determination that a life threatening condition exists.

Signature: _____Relationship:_____Date:_____

Physician Signature: _____ Date: _____

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