BAUGO COMMUNITY SCHOOLS
Medication Authorization

School _____ Grade _____

Student Name _____

Diagnosis for which medication is given _____

Medication _____

Dosage _____ Time(s) to be given _____

Possible Side Effects _____

For Students Required to Carry and/or Self-Administer Medication

*A physician/prescriber's signature is **required** if the student will carry &/or medicate himself/herself.

Has the student been instructed on how to use this medication? _____

Pharmacy _____ Prescription # _____

*Prescriber Signature _____ Phone _____
Physician or Practitioner

NOTE:

- The school system will administer medicines if it is sent in the **original, most recent labeled container**. This form must accompany the medication.
- The student shall be responsible for reporting to the school office at the designated time for the dispensing of medication.
- All medications sent to the school will be stored in the school office, unless otherwise stated. Only the school principal, school nurse, secretary or principal designee shall be allowed to dispense this medication, unless otherwise stated by the parent and physician.
- **On delayed start days**, morning and lunch medications will not be given unless notified by the parent. **Instructions** * _____ *

I give permission for exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regime. I request that my child be assisted in taking the medicine(s) described above at school by authorized persons or be permitted to medicate herself/himself as also authorized by me and my physician (see above).
These instructions shall remain in force until _____ (not longer than the school year) unless you are otherwise informed.
I agree to notify you immediately, **in writing**, of any changes in administering this medication.

Parent Signature _____
Phone _____
Date _____

Fax Numbers: Jimtown High School 294-5596; Jimtown Jr. High 970-2110;
Jimtown Intermediate School 522-7649; Jimtown Elementary 522-3899