DIOCESE OF WICHITA
AUTHORIZATION FOR MEDICATION/PROCEDURE
TO BE ADMINISTERED AT SCHOOL AND FIELD TRIPS

PART A – To be completed by Parent or Guardian

Name of Student: _____ Date of Birth: _____ Grade/Teacher: _____

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school or on a field trip as indicated by my child's health care provider as described in Part B listed below.

I understand I must provide all medication in its original labeled container and/or all necessary supplies. I further understand that school employees who administer any drug to my student in accordance with written instructions from the physician, dentist, physician's assistant, or advanced registered nurse practitioner shall not be liable for damages as the result of an adverse drug reaction suffered by the student because of the administration of such drug.

I certify that the child named above has received at least one dose of the medication requested above and has not had an adverse reaction to it.

I also give permission for communication between the school and the medical prescriber and dispensing pharmacy related to the specific medication/treatment in question, including communication concerning:

1. The prescription or treatment itself – i.e. questions regarding dosage, method of administration, and potential drug interactions.
2. Implementation of the treatment in school – i.e. questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or academic schedule.
3. Student outcomes from the treatment – i.e. questions regarding observed side effects, possible negative reactions, observations of behavior changes in the classroom.
4. Other pertinent issues related to the student's diagnosis, condition, or treatment.

_____	_____	_____
Parent/Guardian Signature	Printed Name of Parent/Guardian	Today's Date
_____	_____	_____
Home Phone	Cell Phone	Work Phone

PART B – To be completed by Health Care Provider

MEDICATION AND/OR TREATMENT ORDERS: (please specify)

Medication/Treatment	Dosage/Route	Time/Frequency	Diagnosis(es)/Indication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Special Instructions: _____

_____

_____	_____	_____
Signature of Physician/APRN/PA	Printed Name of Physician/APRN/PA	Name of Supervising Physician for APRN/PA
_____	_____	_____
Health Care Provider Phone	Health Care Provider Fax number	Date

GUIDELINE 317-T FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

- This policy applies to all prescription and over-the-counter drugs, natural and homeopathic remedies and food supplements.

- A written note signed by a doctor or dentist requesting that the medication be given during school hours must accompany all medications and include the following: name of student, name of medication, dose amount and time to be given, and the anticipated number of days the medication will be taken at school.

- A written request for the medication to be given at school, signed by the parent, must accompany all medication.

- The medication must come in an official prescription container or the original over-the-counter packaging. It is the parent's responsibility to supply the medication and assure that it is the same as identified on the label.

- Parents must certify that the student has received at least one dose of the medication and has not had an adverse reaction to it.

- Any changes in the type of drug, dosage or time of administration must be accompanied by new parent and physician permission signatures and new or newly labeled containers.

- Annual renewal is required.