USD 465 Winfield Public Schools
Authorization for Medication/Procedure to be Administered at School and Field Trips

Part A Parent/Guardian to Complete

Name of Student: _____ Date of Birth _____ Grade _____

I grant permission for the school nurse or delegated staff member to administer medication/treatment to my child at school as indicated by my child's physician accordingly below. I understand that I must provide any medication in its original labeled container.

I also acknowledge the need and give permission for appropriate communications between the school nurse and the medical prescriber related to the specific treatment in question, including communication concerning: 1. the prescription or treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube); 2. implementation of the treatment in school (e.g., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule); 3. student outcomes from the treatment (e.g., questions regarded observed side effects, possible untoward reactions, observations of behavior changes in the classroom); and 4. and other pertinent issues related to the student's diagnosis, condition or treatment.

_____ _____ _____
Parent signature Parent printed name Today's date

Part B Physician/Dentist to Complete

Current Diagnosis(es): _____ _____ _____

Physician Medication and/or Treatment orders: (please specify)

Medication/Treatment	Dosage	Time/Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special Instructions: _____

_____

_____ _____ _____
Physician signature Physician printed name Today's date

_____
Physician Phone Number