

**CARETAKER AUTHORIZATION FOR
ADMINISTRATION OF PRESCRIPTION MEDICATION TO STUDENT**

The undersigned(s) is/are the caretaker(s), parent(s), guardian(s), or person(s) in charge of _____ (“the Student”).

It is necessary that the Student receive _____ (medication), _____ (amount of medication) at _____ (time to be administered), _____ (route), over the counter or physician-prescribed medication, during school intervals beginning on _____ (date) and continuing through _____ (date).

CHECK ONE (1) OF THE FOLLOWING BOXES

_____ I hereby authorize Arlington Public Schools to allow the Student to administer the above-described medication to himself/herself without monitoring or supervision by school personnel.

_____ I hereby request Arlington Public Schools, or its authorized representative, to administer the above-named medication to the Student, in accordance with the prescribing physician’s instructions, and agree to:

1. Submit this request to the principal or school nurse.
2. Make certain the Physician’s Request for the Administration of Prescription Medication by School Personnel is submitted to the principal or school nurse.
3. Make sure personally that the medication is received by the principal or school nurse and/or designed school personnel, in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
4. Make sure personally that the container in which the medication is in is marked with the medication name, dosage, interval dosage, and date after which no administration should be given.
5. Submit a REVISED STATEMENT signed by the physician prescribing the medication to the principal or school nurse IF ANY OF THE INFORMATION PROVIDED BY THE PHYSICIAN CHANGES.
6. Provide directions to the school personnel providing the medication.
7. Provide monitoring of the medication's effects, and assume full responsibility therefore.

I understand that unlicensed school personnel may be assigned to provide medication to the Student and hereby release the School District and the Board of Education of the School District and all employees, agents, and representatives of the School District from any liability concerning the providing or non-providing of the medication to the Student. In addition, I give the school nurse permission to contact the prescriber as needed and to share medical information with appropriate school personnel.

DATED this _____ day of _____, 20__.

Work Telephone Number

Name of Student

Home Telephone Number

Parent/Guardian

Alternate Number for Parent

Parent/Guardian