PRESCRIPTION / NONPRESCRIPTION
MEDICATION AUTHORIZATION 2020-2021

Students Name:_____DOB: _____Allergies:_____

I am the parent/guardian with legal custody of the above-named student who attends Jefferson West Schools. I am requesting that the following medication be administered to my child. I certify that my child has previously had at least one dose of the medication and has had no adverse reaction. I give my consent and authorize the school nurse, principal, or other designated school employee to administer the medication according to the prescription label and/or doctors written order. I give permission for information on this page to be shared with appropriate educational and office staff as deemed necessary by the school nurse or building principal for the safety and well-being of child.

I understand that under state law and board policy that Jefferson West Schools and employees of Jefferson West Schools will not be liable to the student or student's parent/guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering the medication I have hereby authorized.

Parent/Guardian Signature: _____ Date: _____

PRESCRIPTION MEDICATION:

Administer Per Prescription Label	Administer Per Attached Doctor's Order
Name of Medication:	
Dosage to be Administered:	Time to be Administered:
Reason to be Administered:	
Name of Physician: Physician Signature:	Expiration Date of Medication: Date:

NONPRESCRIPTION MEDICATION:

Administer Per Label Instructions	Administer Per Attached Doctor's Order
Name of Medication:	
Dosage to be Administered:	Time to be Administered:
Reason to be Administered:	
Expiration Date of Medication:	

***Medications from foreign countries and Homeopathic, Herbal, Essential Oils, and other natural remedies will not be administered by Jefferson West USD 340 employees.**

School Nurse: _____ Date: _____

MEDICATION DOCUMENTATION
MUST BE COMPLETED AT TIME OF MEDICATION ADMINISTRATION

Student Name:	**Grade:**
Medication Dosage, Time, Route:	
Care Provided By: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	

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