Sioux City Community Schools
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AUTHORIZATION FOR MEDICATION
or PROCEDURE ADMINISTRATION
Board Policy 504.12-E(ii)

Student: _____ Birthdate: _____
School: _____ School Year: _____

Medication/Procedure, which cannot be managed at home, shall be administered at school when the following are on file at the school:

- Physician's signed and dated authorization which includes the: medication/procedure, dosage, route, and time to be given at school, dosage repeat, symptoms, and side effects.
- Parent/Guardian signed and dated authorization.
- Medication/equipment delivered to school in the original packaging.
- A prescription label must be attached to the medication container(s).
- Authorization orders must match the prescription label on the medication container(s).
- Annual renewal of authorization and immediate notification, in writing, of changes.
- Medication/Equipment will be kept in a secured area and shall be administered by qualified staff.

MEDICAL PROVIDER AUTHORIZATION SECTION (To be filled out by medical provider)

The above named student is under my medical supervision. I have prescribed the following:

_____

Name of Medication mg or Procedure **Dosage @ school** **Route**

_____

Time given @ school **Diagnosis & ICD-10 code (Must have for Medicaid)**

_____

Anticipated reactions/possible side effects

Physician Signature_____ Date_____
Phone_____ Fax _____

PARENT AUTHORIZATION SECTION

I request the above pupil be given the following while in school and school related activities. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication/procedure where the person administering the medication/procedure acts as an ordinarily reasonable prudent person would under the same or similar circumstances.

_____

Name of Medication/mg or Procedure **Dosage @ school** **Time @ school** **Route**

Child's Physician_____

Parent Signature_____Date_____

Phone: Home_____Work_____ Cell_____