LITTLE ROCK SCHOOL DISTRICT
HEALTH SERVICES

*A separate form must be completed for **each** medication administered.*

CONTROLLED MEDICATION AUTHORIZATION AND RELEASE

Student name: _____ **Date of Birth:** _____ **Grade:** ____ **Teacher:** _____

Name of Medication _____ **Dosage to be taken** _____ **Time** to be Taken _____

Reason(s) for Medication / Diagnosis _____

Parent(s) Phone Numbers: Home _____ Work: _____ Cell: _____

In case of emergency call: _____ phone(s): _____

Hospital to be called: _____ phone: _____
Doctor to be called: _____ phone: _____

I certify that at least one dose of the medication has been previously given and NO adverse reactions were experienced. Therefore, I give permission for the school nurse, or trained designee, to administer the above medication to my child.
When the school nurse is not available, I, the parent/ guardian, delegate the following staff members to administer this oral controlled medication to my child.

_____ or _____ or _____
Designee Name Designee Name Designee for Field Trip

The school nurse has permission to contact the prescribing physician for information relating to this medication.
The school nurse, or designee, has my permission to take a photo of my child and place it on his/her medication record for identity purposes.
I acknowledge that the District, its Board of Directors, and its employees shall be immune from civil liability for damages resulting from the administration of this medication in accordance with this consent form.

Parent or Guardian _____ **Date** _____

DATE	Received or Picked Up by	Medication Count (Number of pills or liquid)	Signature	Signature	Comments