

Medication Agreement

*Annual Authorization from a Parent / Guardian and a Healthcare Provider
Is Required For All Medication*

To be completed by parent or guardian

I hereby request and give my permission to the Jefferson County School District to administer this medication to my child. I understand that it is my responsibility to provide the medication in the original pharmacy/or physician labeled container that has the correct medication dosage identified for my student. I also understand the school may not alter or change any medications from their original form (cut or half pills, etc.) Any prescription changes will require an additional signed and completed Medication Agreement. I release Jefferson County School District staff from all liability for any injury caused by the administration of the medication in compliance with medication label.

Student Name: _____ Birth Date: _____

Parent / Guardian Name (s): _____ Phone: _____

Name of Medication: _____ Dosage: _____ Time: _____

Start Date: _____ End Date: _____ Route: _____ Medication Purpose: _____

I understand that the prescribing healthcare provider or designee may disclose to Jefferson County School District staff all protected information for the purpose of review and evaluation in connection with the administration of medication for one year. I acknowledge this exception to HIPAA but if questioned authorize this disclosure.

Signature of Parent/Guardian _____ Date _____

Student Name: _____ Birth Date: _____

Medication: _____ Purpose: _____

Dosage: _____ Time(s) to be given at school: _____

Start Date: _____ End Date: _____ Route: _____

Name of Healthcare Provider: _____ Office Phone: _____ Fax _____

Signature of Healthcare Provider _____ Date _____

Only school staff who are trained and delegated by the District Registered Nurse may administer medications. The employee administering the medication must document and initial the time the medication was administered on the Supplemental Medication Administration Log.

Name / Signature of District Registered Nurse who trained and delegated prior to the administration of the medication.

Initials	Trained & Delegated Staff	Title	Date Delegated
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____