

**CARETAKERS AUTHORIZATION FOR
PROVISION OF PRESCRIPTION MEDICATION TO STUDENT**

The undersigned is the caretaker, parent, guardian, or person in charge of _____
("the student").

It is necessary that the Student receive _____(medication), a physician-prescribed
medication, during school intervals beginning on _____(date) and continuing through
_____(date).

CHECK ONE (1) OF THE FOLLOWING

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

_____ I hereby request the Mead Public School, or its authorized representative, to provide the above-
named medication to the above named Student, in accordance with the prescribing physician's
instructions, and agree to:

1. Submit this request to the building principal.
2. Make certain the Physician's Request for the Provision of Prescription Medication by School
Personnel is submitted to the building principal.
3. Make sure personally that the medication is received by the building principal 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 marked with the medication
name, dosage, interval dosage, and date after which no provision should be given.
5. Submit a REVISED STATEMENT signed by the physician prescribing the medication to the
building principal 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 school personnel, who are not licensed health care providers, may be assigned to provide
medication to my Student and hereby release the Mead Public School District, the Board of Education, and
all employees, agents, and representatives of the Mead Public Schools from any liability concerning the
providing or non-providing of the medication to the Student.

Dated this _____ day of _____, _____

Work Telephone Number

Name of Student

Home Phone Number

Printed Name of Parent/Guardian

Alternate Number for Parent

Signature of Parent/Guardian