School Prescription Medication Authorization Form
(Formulario de autorización de los medicamentos de receta)

Student's Name ____ Birth date ____________________
(*Nombre*) (*Fecha de nacimiento*)
Address ____ Home Phone ____________________
(*Dirección*) (*Numero de teléfono de la casa*)
School ______________________________________ Grade _______ Teacher ____________________
(*Escuela*) (*Grado*) (*Maestro*)
Emergency Phone No. ____
(Numero de teléfono en caso de emergencia)

To be completed by the student's physician:
(Para ser llenado por el médico del estudiante):

Name of Medication ______________________________ Dosage __________ Frequency ____________________

Time to be given in school ______________________ Date of Rx ______________ Date of order ____________

Discontinuation date____________________________ Diagnosis requiring medication______________________________

Intended effect of this medication: ____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medication condition?____________ Expected side effects, if any:______________________________

Time interval for re-evaluation __________ Other medications student is receiving ______________________________

Physician's signature ____________________________Physician's name – printed ______________________________

Address ____

Date ______________ Office Phone ____________________________ Emergency Phone ______________________________

Please use reverse side for further remarks.

__________________ confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Wesclin School District and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

______________________________________ ________________________
PARENT SIGNATURE DATE

__________________ Confirmo que soy el principal responsable de la administración de medicamentos a mi hijo. Sin embargo, en el caso de que no soy capaz de hacerlo o en caso de una emergencia médica, autorizo Wesclin Distrito Escolar y sus empleados y agentes, en mi nombre y lugar, para administrar o para tratar de administrar a mi hijo (o para permitir a mi hijo a auto-administrar, bajo la supervisión de los empleados y agentes del Distrito Escolar), la medicación prescrita legalmente en la forma descrita anteriormente. RECONOZCO QUE ES POSIBLE QUE SEA NECESARIO PARA LA ADMINISTRACIÓN DE MEDICAMENTOS PARA MI HIJO A SER REALIZADO POR UNA PERSONA QUE NO SEA UNA ENFERMERA DE LA ESCUELA, Y CONSIENTO ESPECIFICAMENTE A TALES PRACTICAS. Además, reconozco y acepto que, cuando el medicamento prescrito legalmente es tan administrado o intentado ser administrado, renuncio a cualquier reclamo que pueda tener contra el Distrito Escolar, sus empleados y agentes que surjan de la administración de dicho medicamento. Además, me comprometo a mantener indemne e indemnizar el Distrito Escolar, sus empleados y agentes, ya sea conjunta o separadamente, de y contra cualquier y todo reclamo, daños, causas de acción o las lesiones sufridas o como resultado de la administración o los intentos de la administración de dijo medicamento.

______________________________________ ________________________
FIRMA DE PADRE FECHA

Adopted: May 16, 2005