CANTON ELEMENTARY SCHOOL
Mrs. Cindy Reed, RN, BSN, CSN
545 East Main St., Canton, PA. 17724
PH: (570)-673-5196 FAX: (570)-673-7929

SCHOOL YEAR: _____

CANTON JR. SR. HIGH SCHOOL
Ms. Jennifer Martin, LPN, HRA
509 East Main St., Canton, PA. 17724
PH: (570)-673-5134 FAX: (570)-673-5566

MEDICATION AUTHORIZATION FORM

FOR ALL prescription or **over the counter medications** administered at school
This section must be completed by the PARENT/GUARDIAN (please print)

Student: _____ DOB: _____ Grade: _____

Medication requested: _____ Dose: _____ Time: _____

Instructions: _____ Diagnosis: _____

Significant potential side effects: ☐ none expected ☐ specify _____

Prescribers Name-Title: _____ Phone: _____ Fax: _____

Prescribers Signature: _____

If this medication is an asthma inhaler, epinephrine auto-injector, or other emergency medication, is student authorized to self-carry/ self-administer? _____yes _____no

I request that the authorized persons at school may assist my student in taking the medication described above.

☐ I request that my child be allowed to self-carry and/or self-administer this medication as prescribed and per CASD policy. My student and I understand the responsibility of self-carrying medication at school. I am aware and agree that self-carry and/or self-administer of the above medication may be revoked at any time my student doesn't follow prescribed instructions and/or school policy. The above **student** understands and agrees to **inform the nurse when they self-medicate for documentation.** I agree to hold harmless and indemnify the school and Canton School District employees, and agents against all claims, judgements, or liabilities arising out of the self-administration and carrying of medication by my student.

☐ As a CASD student I agree to store and use my medication as instructed on the prescription bottle and CASD policy. I agree to contac the school nurse, teacher, or event organizer immediately if any problems or emergency situations occur. **I also agree to inform the school nurse immediately anytime the medication is self-administered for documentation purposes.**

PARENT/GUARDIAN REQUEST & AUTHORIZATION:

I request designated school personnel to administer the medication as prescribed by the above provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I authorize the school nurse to communicate with the above health care provider/facility regarding my student's health that's required and as allowed by HIPPA.

Parent/Guardian Signature: _____ Date: _____

Home/Cell Phone #: _____ Work #: _____ Email: _____

Student signature if self-carry/ self-administer medication as stated above: _____ Date: _____

Self-carry/self-administration of medication (including emergency medication) that is authorized by the prescriber above must be approved by the school nurse according to the CASD medication policy.

School Nurse approval for self-carry/self-administration of medication. _____ Date: _____

Date	# pills	Nurse Initials	Witness

* Prescription medication must be in a container labeled by the pharmacist or prescriber
* Non-prescription medication must be in the original container with label intact
* An adult must bring the medication to school unless authorized different through the Nurse
* The *school* Nurse will call the prescriber if a question arises about the child and/or the child's medication

****Canton Area School District is an Equal Opportunity Employer in Compliance with Title IX and Section 504****