CENTRALIA R-VI SCHOOL DISTRICT

Dr. Steven Chancellor
Superintendent

steven.chancellor@cr6.org
www.ccr6.org

123 N. Rollins Street
Centralia, Missouri 65240

(p) 573-682-3561
(f) 573-682-2181

Authorization for medication to be taken during school hours

ADMINISTRATION OF MEDICATION/S TO STUDENTS

Student Name: _____ Age: _____ Date of Birth: _____

School: _____ Grade: _____

**Known drug allergies: (list) _____

Name of Medication to be given at school: _____

Physician Name: _____ Phone #: _____

Reason for Medication: _____

Time to be given: _____ Dosage to be given: _____

****All medication MUST be in the original container or prescription bottle****

_____ Daily until gone or refill obtained from parent
_____ As needed

I give permission for _____ (student's name) to receive the above medication at school.

I give district employees permission to contact the student's physician directly to provide information on the student's condition or to obtain clarification of orders. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school district immediately if any information provided on this form changes or if administration of medication should cease. I have given the first dose of this medication, per Centralia R-VI district policy.

I give district employees permission to share health information of the above named student with other district employees, health care providers, and the students emergency contact person on a need to know basis. In the case of an emergency, the student may be transported by medical emergency services.

_____ _____

Parent/Legal Guardian Signature Date

Notice

In the event of severe allergic reactions that cause anaphylaxis epinephrine will be administered in accordance with protocols provided by the authorized prescriber, except for students authorized to carry and self-administer epinephrine in accordance with Board Policy.