AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

SECTION 1: TO BE COMPLETED BY PHYSICIAN

Name of Child: _____ Date of Birth: _____

Home Address: _____ Emergency Contact Name/Phone_____

I have prescribed the following medication(s) for the above-named child, who needs, or may need, to take the medication(s) while in the White Bear Lake Area School District's out of school time programs.

Medical Condition	Medication	Strength	Dose	Time	Route	Possible Side Effects

Other Directions/Considerations: _____

The above-named child is knowledgeable about the following medication(s), which are listed above, and may safely self-administer the following medication(s) (does not apply to controlled substances):

_____ _____

_____ _____

Print Name of Physician/Licensed Prescriber Physician's/Licensed Prescriber's Signature

_____ _____ _____

Clinic Address Phone Number Date

SECTION 2: TO BE COMPLETED BY PARENT/GUARDIAN

1. I am the parent or legal guardian of the above-named child ("my child"). I have the legal right to make medical decisions on behalf of my child.
2. I am requesting that White Bear Lake Area School District's out of school time program administer the medication(s) listed above to my child while my child is participating in the program and any related activities. In making this request, I understand that the medication(s) will be administered by School District employees who are not medical professionals. The medication(s) will not be administered by a school nurse.
3. I understand that the District's out of school time programs provides a service for the benefit of parents and guardians that is separate from the K-12 program of education that the White Bear Lake Area School District offers for the benefit of students.
4. I understand that Community Services & Recreation staff members do not have access to any medication(s) that the school nurse may maintain in the health office. I understand that in order for program staff to administer medication(s) to my child, I must deliver the medication(s) directly to the program staff in the original prescription container, which must contain the original label.
5. I knowingly and voluntarily release the District and its employees, officials, agents, and insurers from liability for any harm that may result from administering the above medication(s) to my child, or from permitting my child to take the medication(s), as prescribed by my child's physician or licensed medical provider.
6. I agree to immediately notify Community Services & Recreation program staff of any change in my child's medical condition or prescription medication(s), including, for example, any change in the strength, the dosage, or the type of medication that

is prescribed.

7. I authorize District employees who work in the community education programs to receive information from, and to provide information to, my child's physician and licensed medical providers about my child's health condition(s) and the effect of the medication(s) that are listed above. I agree to sign any additional forms that are necessary to allow my child's medical providers to communicate with District employees who work in the program about my child's prescription medication(s), the effect of the medication(s), and the condition(s) the medications are meant to treat.
8. My child is knowledgeable about the following medication(s), which are listed above, and I am requesting that my child be permitted to self-administer the following medications (does not apply to controlled substances):

_____ _____

Print Parent/Guardian's Name	Signature of Parent/Guardian	Date

RASW: 108468