DIOCESE OF WICHITA
AUTHORIZATION FOR MEDICATION/PROCEDURE
TO BE ADMINISTERED AT SCHOOL AND FIELD TRIPS

PART A – To be completed by Parent or Guardian

Name of Student: _____ Date of Birth: _____ Grade/Teacher: _____

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school or on a field trip as indicated by my child's health care provider as described in Part B listed below.

I understand I must provide all medication in its original labeled container and/or all necessary supplies. I further understand that school employees who administer any drug to my student in accordance with written instructions from the physician, dentist, physician's assistant, or advanced registered nurse practitioner shall not be liable for damages as the result of an adverse drug reaction suffered by the student because of the administration of such drug.

I certify that the child named above has received at least one dose of the medication requested above and has not had an adverse reaction to it.

I also give permission for communication between the school and the medical prescriber and dispensing pharmacy related to the specific medication/treatment in questions, including communication concerning:

1. The prescription or treatment itself – i.e. questions regarding dosage, method of administration, and potential drug interactions.
2. Implementation of the treatment in school – i.e. questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or academic schedule.
3. Student outcomes from the treatment – i.e. questions regarding observed side effects, possible negative reactions, observations of behavior changes in the classroom.
4. Other pertinent issues related to the student's diagnosis, condition, or treatment.

Parent/Guardian Signature	Printed Name of Parent/Guardian	Today's Date
Home Phone	Cell Phone	Work Phone

PART B – To be completed by Health Care Provider

MEDICATION AND/OR TREATMENT ORDERS: (please specify)

Medication/Treatment	Dosage/Route	Time/Frequency	Diagnosis(es)/Indication

Special Instructions: _____

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Signature of Physician/APRN/PA	Printed Name of Physician/APRN/PA	Name of Supervising Physician for APRN/PA
Health Care Provider Phone	Health Care Provider Fax number	Date