Grade _____

AUTHORIZATION AND INSTRUCTIONS FOR MEDICATION ADMINISTRATION

(This form must be accompanied by measuring device and medication that is labeled by the pharmacist or physician or over the counter medication that is in its original packaging in order for school to administer medication).

PART A: To be completed by **PARENT/GUARDIAN**

I authorize the non-public school/camp nurse, or other unlicensed assistive personnel (UAP) educated by the nurse, to administer the below medication to my child during regular school/camp hours and at other times when my child is participating in a school/camp related event. I understand that the district, school/camp, school/camp nurse and other school/camp employees shall incur no liability as a result of any injury arising from the administration of this medication or procedure; that I will indemnify and hold harmless Lubavitch on the Palisades and its employees, against any claims arising from the administration of medication to my child.

Signature of Parent/Guardian _____ Date _____

PART B: To be completed by **PRESCRIBING HEALTH CARE PROVIDER**

NAME OF CHILD: _____ DOB: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSAGE: _____

FREQUENCY & DIRECTIONS: _____

PURPOSE OF DRUG/PROCEDURE: _____

POSSIBLE SIDE EFFECTS: _____

APPROPRIATE FOR DELEGATION TO UAP: **(MUST BE CHECKED)** ○ YES ○ NO

Signature of Health Care Provider:_____ Date: _____

Address: _____ Telephone: _____

This authorization is effective for the current program only and must be renewed annually.