BISMARCK PUBLIC SCHOOLS

Bismarck Public Schools
MEDICATION ADMINISTRATION AUTHORIZATION:
MIDDLE/HIGH SCHOOLS

Directions for Parent: Please complete this form if your child will be taking any medication while on school grounds or during District-sponsored activities this school year. (**Exception: reliever inhalers and Epipens).** If taking more than two medications, please use another form.

Student:_____ DOB:_____ School/Gr:_____

MEDICATION #1 (Please Print):

Medication Name/Strength:_____ How Many:_____ Time to Give @ School:_____
Route (Circle One): By Mouth Inhaled/Nasal Apply to Skin Apply to Eyes Drop into Ears Other:_____
Reason for Medication:_____ Continue Until:_____
Instructions for Use:_____
Major Side Effects:_____
Authorization (Check One):
___ I authorize my child to securely keep/store, and self-administer the medication listed above.
___ I authorize BPS Staff to securely keep/store and administer the medication listed above to my child.

MEDICATION #2 (Please Print):

Medication Name/Strength:_____ How Many:_____ Time to Give @ School:_____
Route (Circle One): By Mouth Inhaled/Nasal Apply to Skin Apply to Eyes Drop into Ears Other:_____
Reason for Medication:_____ Continue Until:_____
Instructions for Use:_____
Major Side Effects:_____
Authorization (Check One):
___ I authorize my child to securely keep/store, and self-administer the medication listed above.
___ I authorize BPS Staff to securely keep/store, and administer the medication listed above to my child.

I authorize the BPS to contact the following health care provider if concerns or emergencies arise regarding my child and the medications listed above: Provider:_____ Ph. #:_____

In exchange for granting my request to permit my child to self-administer the above-named medication(s), I agree as follows: (1) To indemnify, defend and hold harmless the Bismarck Public School District, its officers, employees and all other individuals working in their official capacities on behalf of the District from any claim or liability for injuries or damages resulting from the self-administration of the above-named medication; and (2) To acknowledge that I will not seek any recovery from the District for any claim or liability for injury or damages, including without limitation reasonable attorneys fees and costs, caused or claimed to be caused by the self-administration of the above-described medication.

Parent Signature:_____ Date:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____

NOTE: This Authorization shall remain in effect for one school year (including summer school programs after the school year). Please note that new "Authorization" forms must be completed prior to the start of each new school year.