Council Bluffs
Community School District
...Where Dreams Begin!

Student Full Name: Date of Birth:

School: Date:

School medication and health care services are administered following these guidelines.

- Parent signed and dated authorization to administer the medication.
- The medication is in the original labeled container as dispensed or the manufacture's labeled container.
- The medication label contains the student name, name of the medication, directions for use and date.
- Annual renewal of authorization and immediate notification, in writing of changes.

Medication/Health Care:

Dosage: Route:

Time at School:

Administration Instructions:

Discontinue/Re-Evaluate/Follow Up Date:

Doctor's Signature: Date:

Doctor's Address:

Emergency Phone:

I request the above student be given the medication at school and school activities by qualified staff, according to the prescription or non prescription instructions and a record be maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinary reasonable prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment or it will be properly destroyed.

Parent Signature: Date:

Parent's Address: Phone Number:

Additional Information: