Exhibit **Form ACBD-E2**

Dickinson Public Schools
Medication Administration Authorization
Dickinson Middle School and Dickinson High School

Office Use Only
School Year:
Alert in PS:
Date Discontinued:

Directions for Parents/Guardians: Please complete this form if you want DPS staff to administer prescription or non-prescription medications to your child.(Exception: reliever inhalers and EpiPens) (1) This form must accompany each medication to be administered; (2) This form must accompany each new medication or change in dosage/time of day that may occur during the school year; (3) Physician signature is required for all prescription medication and over the counter medication (when the dose given is different than the recommendation on the box); and (4) All types of medications must be in their original containers and labeled with child's name. An **adult must deliver** your child's medication to school staff or it cannot be accepted. Thank you for your cooperation!

Name of Student:	**DOB:**	**Teacher/Grade:**
Name of Medication:	**Dose:**	**Time/Frequency:**
Route (Circle one): By Mouth Inhaled Nasal Apply to Skin Eyes Ears Injection		
Reason for Medication:	**Start Date:**	**End Date:**
Instructions for Use:		
Major Side Effects/Adverse Reactions to be aware:		
Other Information Staff Should Know about Student and this Medication:		

Prescribing Physician (print):	**Phone #:**
Physician's Signature: ****Student has been instructed and may administer own medication YES NO**	**Date:**

AUTHORIZATION (CHECK ONE)

_____I AUTHORIZE MY CHILD TO SECURELY KEEP/STORE, AND SELF-ADMINSTER THE MEDICATION LISTED ABOVE. STUDENT HAS BEEN INSTRUCTED BY HEALTH CARE PROVIDER ON SELF-ADMINSTRATION.

_____I AUTHORIZE DPS STAFF TO SECURELY KEEP/STORE AND ADMINSTER THE MEDICATION LISTED ABOVE TO MY CHILD

Authorization:

- I give permission to Dickinson Public School personnel and/or medical personnel, designated by the School District, to administer this medication. I understand that administration of this medication will not necessarily be done by a nurse.
- I have read, understand, and agree to comply with the District's medication Policy
- I will notify the school immediately if my child's health status changes or this medication is discontinued.
- I understand that expired medication will not be given and will ensure that all medications are current and up to date.
- I give permission to School personnel and designated medical staff to dispose of medications at the end of the school year if I have not picked them up.
- I give permission to School personnel and designated medical staff to contact the healthcare provider as needed; and that medication/health information may be shared with staff that needs to know.

I have read and understand the "Directions" and "Authorization" sections listed above. I authorize school personnel (and medical personnel designated by the District) to administer this medication to my child. YES NO

Parent signature: _____Date:_____ Daytime Contact number: _____

Student Consent (Grades 6-12)

I acknowledge that I have read, understand, and agree to comply with the District's medication policy. I also agree to comply with the District's drug and alcohol free school policy, which contains restrictions related to medications, including rules probititing me from giving medication to other students.

If at anytime I believe that I am having a reaction to my medication, I will report this information to my teacher or another staff promptly.

I agree that I will not leave the medication unattended or unsecured or accessible to other students.

Student signature: _____ Date: _____

Guardian Consent

In exchange for granting my request to permit my child to self-adminster the above-named medication(s), I agree as follows: (1) I indemnify, defend and hold harmless the Dickinson Public School District, it's 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 limitiation reasonable attorney's fees and costs, caused or claimed to be caused by the self-adminstration of the above- described medication.

Name of Parent/Guardian (please print) Daytime Contact Phone Number

Signature of Parent Today's Date

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.