AUTHORIZATION FOR DESIGNATED EMPLOYEE TO ADMINISTER MEDICATIONS AT SCHOOL

Name of Employee: _____

School: _____ School Year: _____

The above named employee is designated by the school principal to administer medications to students at school during the current school year.

Principal's Signature: _____

Medication Administration Training

The above named employee has completed the school Medication Administration Training Program provided by the school nurse.

School Nurse's Signature: _____

Date of Training: _____

Employee Affidavit

I hereby certify that I have attended a Medication Administration Training Program in the _____ Public Schools and that I understand and will follow the medication policy and procedures outlined in board policy and the Medication Handbook to the best of my ability. I understand that maximum confidentiality of the medical condition and/or medication information of students must be maintained.

Employee's Signature: _____ Date: _____

*The original will be kept in the principal's office and a copy sent to Health Services.