Authorization for Medication Administration by School Personnel

To _____ Of: _____
Principal *School Name*

Student Name: _____ DOB: _____ Grade: Teacher: _____

I am giving school personnel permission to administer medications to my child per the following:

Parent or Physician please complete:

Medication: _____

Dose *(how much)* _____

Tablets requiring cutting should be cut by the parent before being sent to school. Liquid medication requires dosage spoons, available from your pharmacist, to be supplied by parent

☐ Non Prescription

☐ Prescription Rx number: _____

☐ Please allow my child to self-administer this medication. (refer to district policy on self-medication). *Requires self-medication agreement form to be signed by parent, school administrator, and if prescription, consent of physician. (See below)*

Route: (Circle one)

By: Mouth Ear Eye Nose Skin Inhalation

Time to be given @ school: _____

Duration: Start date: _____ End Date: _____

Reason for Medication:

Special Instructions:

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

Parent/Guarding Signature: _____ Date: _____

This authorization applies only to the medication listed above and for the duration of treatment or school year. This also authorizes an exchange of information, as necessary, between appropriate school personnel, and/or my child's health provider.

Physician Direction

(Required in writing or on pharmacy label for all prescription medication)

☐ I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate.

☐ Special instructions including adverse reactions and action required: _____

_____

_____ _____
Physician's Name (please print/stamp) *Address*

_____ _____
Physician's Signature *Phone#* *Effective Date*

ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.