MEDICATION AUTHORIZATION

DEAR PARENTS:

Some students are able to attend school only through the effective use of medication. If possible, all medication should be given by the parent/guardian at home. When this is not possible, school personnel (school nurse or persons designated by school policy) may administer medications if the following requirements are met:

1. This form must be completed for each medication whether it is for a prescription or over-the-counter medication such as Tylenol. **Parental signature is required for both prescribed and non-prescribed medications. A physician's signature is required for all prescription medication. Aspirin is not recommended for school age children and will not be given at school unless ordered by a physician.**
2. Medication must be dropped off by a parent, guardian, or other authorized adult along with this completed medication form the day the child is to start taking the medication. The medication will be logged in on a Medication Inventory Record.
3. The medication is delivered to the school in the original labeled container in which it was dispensed by the prescribing physician, licensed pharmacist, or manufacturer.
4. A written physician's statement or new form is needed if any of the required medication information should change.

Student Name:	School:
Address:	Grade:
Phone Number:	Allergies:

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PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL:

Name and dose of the drug_____

Times or intervals to be administered_____

Adverse reactions that should be reported to physician_____

Special instructions_____

Date to begin_____Date to end_____

Print name, address, and phone number of physician_____

_____

***Physician Signature**_____Date_____

I request that this medication be administered to my child during school hours. I give permission for the school nurse to contact the physician regarding administration of this medication in the school setting, and to share medication information with appropriate school personnel as necessary.

***Parent/Guardian Signature**_____Date_____

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PARENT'S REQUEST FOR THE ADMINISTRATION OF NON-PRESCRIBED MEDICATION BY SCHOOL PERSONNEL:

Name and dose of the drug_____

Times or intervals to be administered_____

Specific conditions for using this medication_____

Physician's name, address, & phone number_____

_____

I request that this medication be administered to my child during school hours. I give permission for the school nurse to contact the physician regarding administration of this medication in the school setting, and to share medication information with appropriate school personnel as necessary.

Parent/Guardian name_____

Address_____

Home phone number_____Work phone number_____

***Parent/Guardian Signature**_____Date_____

Please contact the school for additional medication authorization forms. Thank you. Revised 3/14