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.

Route: (circle one)
By: Mouth Ear Eye Nose Skin Inhalation

Time to be given at school:

Duration: Start date_____end date_____

Reason for Medication:

Special Instructions:

☐ 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)*

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

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/Guardian 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 the school nurse, appropriate school personnel, and/or my child's health provider.

***PHYSICIAN DIRECTION**
(required in writing or on pharmacy label for all prescription medications).

☐I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate.
☐Please allow this student to carry and self-administer this medication. (Must be allowed by school district policy. Student must be developmentally and behaviorally able to self-administer.)
☐Special instructions including adverse reactions and action required:_____

_____

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

_____ _____ _____
(Physician's Signature) (Phone #) (Effective Date)