

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 come from home along with this completed form the day the child is to start taking the medication. A signed note from the physician is acceptable until the parent can get the proper form. **You must provide the medication.**
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:

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 _____

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.

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