

## Authorization for Medication Administration by School Personnel

Student Name \_\_\_\_\_ D.O.B \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Instructions provided by your doctor are needed in order for your child to take prescription medication at school. This is obtained from the prescription label. Only medication in the original container with a prescription label will be accepted. All over-the-counter medication must be accompanied by parent's signature, complete instructions, and must be in the original container.

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

Parent/Guardian please complete:

Medication (name and strength) _____ _____	<input type="checkbox"/> Non-prescription
Dose (how much): _____	<input type="checkbox"/> Prescription Rx number _____
Frequency (how often): _____	<input type="checkbox"/> Please allow my child to self-administer this medication. (Refer to district policy on self medication)
How given: (circle one) by Mouth Ear Eye Nose Skin	<input type="checkbox"/> Possible medication side effects: _____ _____ _____
Time: _____	
Duration: Start date _____ End date _____	
Reason for Medication: _____ _____ _____	
Special instructions: (such as give crushed in food or liquid) _____ _____ _____	

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.

This authorization applies only to the medication listed above 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.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_