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:

Medication (name and strength)_____ _____ Dose (how much):_____ Frequency (how often):_____ How given: (circle one) Mouth Ear Eye Nose Skin Time:_____ Duration: Start date_____ End date_____ Reason for Medication:_____ _____ _____	Special instructions: (such as give crushed in food or liquid):_____ _____ _____ ☐ Non- prescription ☐ Prescription RX Number _____ ☐ Please allow my child to self-administer this medication. (Refer to district policy on self medication) ☐ Possible medication side effects: _____ _____ _____ _____

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:_____