

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 (**Remember to check appropriate boxes below**):

Medication:	<input type="checkbox"/> Non prescription
Dose(how much)	<input type="checkbox"/> Prescription Rx number _____
<i>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.</i>	<input type="checkbox"/> 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)
Route: (circle one) By: Mouth Ear Eye Nose Skin Inhalation	
Time to be given at school:	ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.
Duration: Start date _____ end date _____	
Reason for Medication:	
Special Instructions:	

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	
_____ Physician's Signature	_____ Phone #	_____ Effective Date