



SCHOOL MEDICATION AUTHORIZATION

- The parent or legal guardian must complete and sign this form. (Physician must also sign for prescription medication.) This form must be on file in the student’s health record at school before prescription, non-prescription or over-the-counter medication can be brought into the building and administered. **To ensure safety, a separate form is required for each medication.**
- No student may provide prescription or over-the-counter medication to another student. Students violating this will be disciplined according to the drug use provision of the student code of conduct.
- Medication must be taken in the presence of the School Nurse or other Board designated personnel.
- **Medication must be registered with the School Nurse, immediately upon entry into the building. It must be in the original container and be properly labeled with the student’s name, prescriber’s name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug’s expiration when appropriate.**

Student Name _____ Program _____ School Year _____

List any known drug allergies/reactions _____

Name of Medication _____

Reason for Taking _____

Dosage _____ Route _____ Frequency/Time(s) to Be Given _____

Begin Medication _____ Date _____ Stop Medication _____ Date _____

Special Instructions: If asthma inhaler, do you recommend this medication be kept “on person” by the student? Yes ___ No ___

Potential Side Effects/Contraindications/Adverse Reactions: _____

Treatment order in the event of an adverse reaction: (Attach additional sheet if necessary) _____

Parent Authorization

I am the parent/legal guardian of _____, and I hereby request and give my permission to the School Nurse or other Board-approved personnel to supervise my child in administering the following prescribed and/or over-the-counter medication. I further acknowledge by signing this form that the school district or its personnel are under no obligation to render assistance in administering medication and do hereby release all Board designated school employees and the Board of Education from liability for damages, illness or injury resulting from either performing or not performing the assistance requested. I have read and understand the above procedures and guidelines.

Signature of Parent or Guardian **Date**

If questions or problems arise, my daytime phone number is _____.
 Other numbers where I can be reached include: (H) _____ (W) _____ (C) _____

If prescription medication: _____
Physician’s Signature **Date**