

# 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:

Medication: _____	<input type="checkbox"/> Non Prescription
Dose (how much) _____	<input type="checkbox"/> Prescription Rx number: _____
<small>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.</small>	<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 @ school: _____	
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/Guarding 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 appropriate school personnel, and/or my child's health provider.

### Physician Direction

*(Required in writing or on pharmacy label for all prescription medication)*

- I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate.
- Special instructions including adverse reactions and action required: \_\_\_\_\_

\_\_\_\_\_  
Physician's Name (please print/stamp) Address

\_\_\_\_\_  
Physician's Signature Phone# Effective Date

ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.