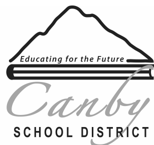

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Authorization for School Personnel to Administer Medications

Student Name:____DOB:_______________

School/Teacher:____Grade:_________

Physician Name:____ School Year:___________

Medication Name:______________________________ Pharmacy_________________

Medication Dose:______________________________ Rx#_____________________

Medication Route (mouth, eye drop, etc.):_________________________________

Frequency/Time given during school hours:________________________________

Duration (day, week, month, school year):_________________________________

Reason for Medication:____

Possible Side Effects:____

Parent/Guardian Request/Approval

I hereby request and give my permission for the above named student to receive the specified medication as stated in the above instruction. I understand that the school administration will designate specific staff to administer medication, train staff, assure proper identification and safekeeping of medication, and maintain records of such administration of medication.

I am responsible to provide this medication to the school in its original container labeled with my child's name, the medication name, dosage, method and frequency of administration, and any special instructions. I will maintain the supply as needed, and that I am responsible to notify the school in writing if there are any changes. Non-prescription medications whose directions for use vary from the directions on the medication label must also be authorized. Parents are required to pick up any unused medication within a week after the last day of school. All medication left at school will be properly disposed of.

I further understand that the school personnel who provide assistance or employer of such staff are not liable in any way civil or criminal, for any adverse reaction suffered by my child as a result of taking the medication so indicated and discontinuing the administration of the medication in keeping with the procedure outlined above. This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel and/or my child's healthcare provider.

This agreement is in effect for the current school year only. I have read and agree to the above criteria

Parent Signature: ____________________________________ Date: __________________

Physician Signature: __________________________________ Date: __________________

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MEDICATION SIGN-IN

Must be completed **each** time a new medication or refill is received from parent.

Medication Name	Date Rec'd	Amt Rec'd	Parent Signature	Staff Signature

** Prescription and non-prescription medications whose directions for use vary from the directions on the medication label must be authorized.*