

**SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION**

**STUDENT INFORMATION**

Student's Name \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_ School Year \_\_\_\_\_

List any known drug allergies/reactions \_\_\_\_\_ Height (inches) \_\_\_\_\_ Weight (lbs) \_\_\_\_\_

**PRESCRIBER AUTHORIZATION**

Name of Medication \_\_\_\_\_ Reason for Taking \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_ Frequency/Time(s) to Be Given \_\_\_\_\_

Begin Medication \_\_\_\_\_ Stop Medication \_\_\_\_\_  
Date Date

**Special Instructions:**

Does medication require refrigeration? Yes No

Is the medication a controlled substance? Yes No

Is self-medication permitted and recommended for this student? Yes No

I hereby affirm that this student has been instructed in the proper self-administration of the prescribed medication(s)

If asthma inhaler or emergency medication, 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 or use the back of this form if necessary)

\_\_\_\_\_  
**Signature of Prescriber**                      **Date**                      **Phone**                      **Fax**

**PARENT AUTHORIZATION**

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to delegate to unlicensed school personnel the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the principal, his/her designee, or the school nurse. 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.

\_\_\_\_\_  
**Signature of Parent or Guardian**                      **Date**                      **Phone**

Over-the-counter medication is not supplied by the school. (Medicines usually include Tylenol, Ibuprofen, Sudafed, Tums, etc.) I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of directors against any claims that may arise relating to my child's self-administration of prescribed medication(s).

\_\_\_\_\_  
**Signature of Parent or Guardian**                      **Date**

If any questions or problems arise, call me at: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_