MEDICATION AUTHORIZATION

SCHOOL YEAR _____

Name	Date of Birth	Grade	*Place student photo here*
Allergies			

Note: Prescription medication must be in the original container indicating the following information: student name, medication, dose, route, time to be administered, and healthcare provider. Over-the-counter medications must be in the original container with clear labeling.

PARENT STATEMENT: I request that the medication listed below be given to my child named above.

- I understand that medication must not be expired.
- I understand that in the absence of the school nurse, other trained school staff may administer medication.
- I understand that the school nurse may contact the health care provider or pharmacist regarding this treatment.
- I will notify the school immediately if the medication is changed.
- I understand that this medication will be destroyed per federal DEA requirements unless picked up by the end of the last student school day of this year.
- I permit the school nurse to share information about my student's health with appropriate school and medical personnel for my student's ongoing safety at school.

Parent/guardian signature	Date	Printed name
Home/cell phone		Emergency number
Other medications taken at home		

HEALTHCARE PROVIDER STATEMENT: This medication is required during school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication. The above-named child should receive prescribed medication for the following condition:

Medication name	Dose	Route
Time	Beginning date	Ending date
Possible side effects		Special instructions
Prescriber signature		Date
Printed name		Phone
Address		
School nurse signature		Date
Printed name		School

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