

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION**STUDENT INFORMATION**

Student's Name _____ Date of Birth _____

School _____ Grade _____ Teacher _____ School Year _____

List of any known drug allergies/reaction _____

_____ 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 NoIs the medication a controlled substance? Yes NoIs self-medication permitted and recommended for this student? Yes NoIf yes, do you recommend this medication be kept "on person" by the student? Yes No

Potential Side Effects/Contradictions/Adverse Reactions: _____

Treatment Order in the event of an adverse reaction: _____

Attach additional sheet or use the back of this form (if necessary)

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

Signature of Prescriber (please print)_____
Date_____
Phone_____
Fax**PARENT AUTHORIZATION**

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to delegate the 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 or 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, unopened, sealed 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 expiration when appropriate.

Signature of Parent_____
Date_____
Phone_____
Cell**SELF-ADMINISTRATION AUTHORIZATION**

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 physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent_____
Date_____
Phone_____
Cell