Jefferson County Schools
Parent/Guardian/Medical Authorization Form to Dispense Medication
This Form is Good for Only One School Year

The parent/guardian is responsible for informing the school of any changes in the student's health or changes in medication. No medication will be administered until information is completed and returned to the school. Medication change requests must be accompanied by the physician's authorization or a new correctly labeled prescription bottle. An up-dated medication authorization form must also be signed by the parent/guardian. Only one form is to be used per medication. Medication must be brought to school and picked up by a responsible adult.

To Be Completed by Parent/Guardian: The following is to be completed by the parent/guardian for any medication to be administered during school hours.

Name of student ____ Date of birth ____________________________

School ___________________________________ Grade ________ Teacher ____

Name of parent/guardian (PRINT): ____

Parent/guardian's home phone: ______________________________________ Work phone: ___________________________

Emergency contact (name and phone): ____

I understand that my child will self-administer the medication with assistance from school staff and I declare that he/she is competent to do so. I assume full responsibility for any side effects and complications my child may have as a result of taking this medication.

Parent/guardian's signature: ____ Date: ________________

Over the Counter Medication: *The following is to be* ***completed by the parent/guardian*** *for all over the counter medications. Medication must be brought to school in the original labeled container with student's name, dosage and time of administration affixed to the container*

Diagnosis for which medication is given: ____

Name of medication and dosage to be given at school: ____

Time, frequency and route (orally, topically, inhalation, injection): ____

If medication is to be given as need, describe symptoms: ____

Duration or last date that medication is to be given at school: ____

Prescription Medication: *The following is to be* ***completed by the physician/nurse practitioner for prescription medications*** *administered during school hours. All medications must be in the currently dated pharmacy/physician labeled container.*

Physician's name and phone number: ____

Pharmacy's name and phone number: ____

Physician's address: ____

Diagnosis for which medication is given: ____

Name of medication and dosage to be given at school: ____

Time, frequency and route (orally, topically, inhalation, injection): ____

If medication is to be given as need, describe symptoms: ____

Duration or last date that medication is to be given at school: ____

Physician's Signature: ____ Date: ___________________________