Short Term Prescription Medication Authorization Request

Student _____ DOB _____ School _____ Grade _____

Note: Prescription medication must be in the original container indicating the following information: *student name, *dosage, *healthcare provider, *pharmacy, *date issued, * and prescription number.

Parent Statement

- I request that the following prescription medication be given to my child, named above, not to exceed 12 school days.
- **For this condition**_____
- I understand that only current medications will be given at school
- I understand that in the absence of the school nurse, other trained school staff will administer the medication
- I give permission for the school nurse to contact the healthcare provider regarding this treatment.
- **I will notify the school immediately if the medication is changed and understand that the nurse may contact the healthcare provider or pharmacist regarding this medication.**
- *I understand that this medication will be destroyed unless picked up by the end of the last student school day of the year.*

Medication _____ **Dose** _____ **Route** _____

Time to be given _____ **Special instructions for administration**_____

Begin Date _____ **End Date** _____ **Count** _____

As parent/guardian of the above named student, I request the Philomath School District to give medication to my child.

Parent/Guardian Signature: _____ Printed Name: _____

Date: _____ Daytime Phone Number (s): _____

Date	Time	Initials