Rochester Public Schools

Authorization for ADMINISTRATION OF MEDICATION

(Staff Administration)

This form must be completed on an annual basis.

STUDENT INFORMATION

Student Name	DOB	Gr	School Year
Medical Conditions		Known Allergies	

CONTACT INFORMATION

Parent/Guardian Name	Phone	Mobile
Parent/Guardian Name	Phone	Mobile

MEDICATION INFORMATION

Medication	Dose	Route	Frequency
End Date	Diagnosis/Reason for taking medication		
Possible side effects			

***NOTE:** All medication must be brought to school by the parent/guardian in the original container. Prescription medication must be labeled for the student by a pharmacist in accordance with law, and must be administered in a manner consistent with the instructions on the label. Mixed dosages in a single container will not be accepted for use at school (for example 5 mg and 10 mg tablets in the same bottle).*

PRESCRIBING HEALTH PROFESSIONAL

Complete this section for PRESCRIPTION MEDICATION or
OVER-THE-COUNTER MEDICATION inconsistent with the package labeling.

Signature	**Date**
Printed Name	Clinic
Phone	Fax

PARENT/GUARDIAN AUTHORIZATION FOR STAFF ADMINISTRATION

I request that the above medication be given to my child during school hours.

I will immediately notify the school of any change in the medication of prescribing health professional's order, dose change, frequency or duration of administration.

I give permission for the school nurse to consult with my child's prescribing health professional concerning any questions that arise with regard to the listed medication, medical condition or side effects of this medication.

I give permission for school staff to administer the medication on a field trip, as necessary. ☐ **YES** ☐ **NO**

Parent/Guardian Signature **Date**