AUTHORIZATION FOR DISPENSING PRESCRIPTION & OVER THE COUNTER MEDICATION

Student's Name: ________________________ D.O.B. ________ Date: _____/_____/______

I understand that:

- **Medications must be in the original labeled container. Pharmacies can provide a duplicate labeled container with only the school doses. All over-the-counter medications must be in original container.**
- All Over-the counter medications that are to be given daily, parents must supply for student.
- Parent/guardian must provide special instructions, as well as the medication and related equipment to the school nurse.
- Medication and refills must be given to the receptionist or nurse by the parent/guardian not the child. **Please provide a 30 day supply at a time**. This ensures students stay on their medications and leave minimal disruption to their day. Parents will be notified when a student has one week left in prescription. It is the parents responsibility to send in prescription medication in a timely manner.
- It is the parents responsibility to notify the school nurse in writing of any medication changes.
- All Epi Pen autoinjectors must be accompanied with an Allergy Action Plan.
- All inhalers must be accompanied by an Asthma Action Plan.
- Seizure medications must be accompanied by a Seizure Plan.

Medication	**Dosage**	**Time to be given**	**Reason for RX**

Physician's name (print): ___________________________Phone Number: _________________

*I request that Swift School administer the **ABOVE MEDICATION(S**) for my child*. I release the school from any and all liability for administering the medication.

Signature of Parent/Guardian __________________________________ Date: ____/____/____
Cell # _____________________________