rawson saunders
Where Dyslexic Means Extraordinary

Medication Authorization Form

ONLY THOSE MEDICATIONS THAT ARE MEDICALLY NECESSARY DURING SCHOOL HOURS FOR A STUDENT'S ATTENDANCE OR DIRECTED BY A HEALTHCARE PROVIDER SHOULD BE SENT TO SCHOOL.

- Parent or guardian must give written permission for medication to be administered at school (Authorization Form)
- ALL medications (prescription AND over-the-counter) must be in their original containers and cannot be expired.
- *Prescriptions* must have the appropriate pharmacy label on the container with student name and dose to be given.
- Over-the-counter medications must have the child's name written on the bottle and the date it was brought it school.
- Over-the counter medication dose must match the manufacturer's recommendation or a doctor's order is required.
- Parent or guardian must hand-off all medications to an adult on campus (students are not to transport medications).

Student Name: _____
Last *First* *Grade:*

Medications Requested

	Medication #1	**Medication #2**
Medication Name and **Strength**:		
Dosage to be given:		
Route (mouth, eye, skin, inhaled):		
Time(s) to be given at school:		
Reason to be given / Diagnosis:		
Medication **Start/Stop Date**:		
To be given on **Field Trips**? **Yes/No**		

Parent Consent and Release of Information

- I request the above medication be given during school hours in accordance with the instructions indicated.
- I release the school personnel from liability in the event of an adverse reaction resulting from taking the medication.
- I give permission for the medications to be given by trained school personnel as delegated by the Head of School.
- I agree to notify the school of any change to the medication or instructions (dosage, time, etc.)
- I will deliver my child's medications to school personnel and **pick up the medications at end of each school year.**

- I give permission for the school nurse to consult with the student's health care provider regarding any questions that arise with regard to the listed medication or medical condition being treated.
- I give permission for the school nurse to communicate with the student's teachers about the health needs of the student and the action(s) of the medications listed above.

_____
Parent/Guardian Name (Printed) **Relationship to Student**

_____
Parent/Guardian Signature **Primary Phone** **Date**

[Office Use Only]
Reviewed by RN: _____ **Date:** _____