HALDANE CENTRAL SCHOOL
MEDICATION AUTHORIZATION FORM

Parent and Prescriber's Authorization for Administration of medication in school or school-sponsored trip

*****A new form must be completed each school year*****

To be completed by a parent or guardian:

Student Name:_______________________________**DOB:**______________**Grade:**______________

I request that my child receive the medication prescribed below by our licensed care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse or other assigned person will assist in the administration of the medication.

Signature (Parent or Guardian) ______________________________________ Date ________________________

To be completed by the licensed health care prescriber:

Medication	Dose	Route	Time(s)

Diagnosis (if applicable)_____________________________________ Duration of treatment________________

Prescriber Name and Title (print): ____

Prescriber Signature: ____ Date: ____________________

Provider Stamp:

Healthcare Provider Permission for Independent Use and Carry:

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed above safely and effectively and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff.

Prescriber signature ____ Date: ______________________

Parent/Guardian Permission for Independent Use and Carry:

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: ____ Date: ________________________