JACKSON PUBLIC SCHOOLS
SCHOOL ADMINISTERED MEDICATION AUTHORIZATION FORM

Whenever possible, parents/guardians should administer medication at home and/or ask the physician to prescribe medication to be given so as to avoid the school day. If medication must be given during the school day, please complete and return to school.

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PART 1 (TO BE COMPLETED BY PARENT/GUARDIAN)

Student ______________________________________ DOB _________ Allergies _____________

School ________________________________ Grade ________ Teacher ___________________________

I hereby request that my child be administered medication at school by school personnel. I understand that the medication will be administered as directed by the physician and health related information would be exchanged with the physician and school personnel as necessary. The physician shall notify the school in writing if this medication is to be discontinued.

Parent/Guardian Name ____

Parent/Guardian Signature ____

Address ____ Zip ________________

Home/Cell # ______________________________________ Work # ______________________________

Date ____

Medication is to be brought to school by parent/guardian and must be in a regulation prescription container, labeled with the date, name of the student and physician, name of the medication and dosage.

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PART 2 (TO BE COMPLETED BY PHYSICIAN)

Physician's Name (Printed) ____ Telephone _________________

Address ____ Zip ________________

Medical condition for which medication has been prescribed ______________________________________

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Name of Prescription ____

Dosage ________________________________ Frequency ______________________________________

Time(s) to be given during school hours ____

Comments regarding medication (side effects, other directions) ___________________________________

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Physician's Signature ____ Date ___________________________