

## ALABAMA STATE DEPARTMENT OF EDUCATION SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

	School Year	
STUDENT INFO	RMATION	
Student's Name:	School:	
Date of Birth: Age: Wt.:		Teacher:
No known drug allergiesAllergies (please list)		
PRESCRIBER AUTHORIZATION (To be comp	oleted by licensed hea	althcare provider)
Medication Name:	Dosage:	Route:
Frequency/Time(s) to be given:	Start Date:	Stop Date:
Reason for taking medication:		
Potential side effects/contraindications/adverse reactions:		
Treatment order in the event of adverse reaction:		
SPECIAL INSTRUCTIONS:		
Is the medication a controlled substance?	☐ Yes ☐ N	0
Is self-medication permitted and recommended?	□ Yes □ N	
<ul> <li>If "yes" I hereby affirm this student has been instructed on the</li> </ul>		
Do you recommend this medication be kept "on person" by stud		•
Cake Icing Gel ONLY FOR Diabetic Student during Bus Transporta		
Printed Name of Licensed Healthcare Provider:		
Signature of Licensed Healthcare Provider:		
PARENT AUTHO	DRIZATION	
I authorize the school Nurse, the registered nurse (RN) or licensed practical nuthe task of assisting my child in taking the above medication in accordance wiparent/prescriber signed statements will be necessary if the dosage of medication must be registered with the School Nurse or	th the administrative code pation is changed.	practice rules. I understand that additional
properly labeled with student's name, prescriber's name, name of me	dication, dosage, time in	tervals, route of administration and
the date of drug's expiration when appropriate.		
<u>Over the Counter Medication</u> must be presented to the School Nurse		_
unopened, and sealed container. <b>OTC medication may not be kept fo</b>		
authorized licensed healthcare provider. Local Education Agency Poli	·='	
Parent's/Guardian's Signature:	Date:	Pnone:
SELF-ADMINISTRATION	I AUTHORIZATION	
(To be completed ONLY if student is authorized for con		sed healthcare provider.)
I authorize and recommend self-medication by my child for the above proper self-administration of the prescribed medication by his/her attached, the agents of the school, and the local board of education against the school and the local board of education against the school and the local board of education against the school and the s	ending physician. I shal	l indemnify and hold harmless the
administration of prescribed medication(s).  Parent's/Guardian's Signature:	Date:	Phone: