

**AUTHORIZATION FOR MEDICATION ADMINISTRATION**  
by Jefferson School District Personnel

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Classroom/Homeroom Teacher \_\_\_\_\_

I am giving school personnel permission to administer medication to my child per the following:

<b>This Section Completed by Parent/Guardian</b>	
Please allow my child to self-administer this medication. (JSD Policy JHCD/JHCD-AR)	
Medication: _____ _____ Dose (how much): _____ Frequency (how often): _____ Route (circle) By: Mouth Ear Eye Nose Skin Time: _____ Duration: Start Date _____ End Date _____	<input type="checkbox"/> Non-Prescription Prescription Number: _____ Medication Expiration Date: _____ Special Instructions: _____ _____ _____ _____ Reason for Medication: _____

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. I also understand parents/guardians are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This authorization applies **only** to the medication listed above and for the duration of treatment or school year. This also authorizes an exchange of information as necessary between appropriate school personnel and/or my child's health care provider.

Permission of the building principal is required for all self-medication requests as per policy JHCD-AR.

\_\_\_\_\_  
Principal's Signature

\_\_\_\_\_  
Date

- medication sign in/sign out on back -

