



Medication Authorization

School Year _____ Grade ___ Class 20___

Student Name:	DOB:	School:
Parent/Guardian 1:	Phone:	
Parent/Guardian 2:	Phone:	
Provider:	Phone:	Fax:
Clinic:	Preferred Hospital:	

Medical Condition	Medication	Strength	Dose	Time	Route	Possible Side Effects

Allergies:

Other considerations/directions:

Start date: _____ **End date:** _____

Parent/Guardian Release/Request for Administration of Medication

- I request that the above medication/treatment be administered to my student as prescribed by the healthcare provider. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
- I understand I must provide medication in the original bottle, properly labeled by the pharmacy with the student's name, date, dosage, time and directions for administration.
- I give permission for the medication(s) to be given by school personnel as delegated by the licensed school nurse.
- I understand and authorize my child's healthcare provider to release or share my child's protected health information regarding this medication and/or medical condition.
- If my student has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my student. I will notify the Health Office if I prefer to pick it up. All controlled substances will need to be picked up. If medication is left over and not picked up within 2 weeks after expiration or conclusion of the school year, it will be disposed of.
- I will immediately notify Health Services of any change in the medication(s) i.e dose change, medication, discontinued, etc.
- I understand it is my responsibility to notify the transportation company directly of any specific directions for my student's care while riding transportation before or after school.

Over the counter pain relievers: This student has been trained and is capable to carry and self-administer while at school (**Grade 7-12 only**): yes no

Provider Signature: _____ Date: _____

Parent Signature: _____ Date: _____

****This form is not meant for inhalers or epi pens. Please complete STMA Allergy and Asthma Action Plans or provide similar form from provider.****