Hazelwood School District
"A Culture of High Expectations and Excellence!"

Dr. Nettie Collins-Hart, Ed.D
Superintendent

PARENT AUTHORIZATION FOR PRESCRIPTION MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS School Year 2024-25

The following section is to be completed by the PARENT:

Child's Name (Last)_____(First) _____

Sex_____Birth Date _____

Home Phone_____ Emergency Phone _____

My son/daughter has the following food or drug allergies: _____

_____I am requesting that, during school hours, the school nurse or designated person administer this prescription medication according to the directions given on the prescription label of the medication or the current physician order, whichever is most recent. I understand the information is confidential according to the Family Rights and Privacy Act (FERPA), and school personnel needing to know have access to this information. I agree to coordinate and work with school personnel if questions arise.

I understand I may cancel this request at any time and/or retrieve the medication from the school at any time. If I do not pick it up, I give permission to the school nurse to destroy any medication remaining at the end of the school year.

Parent/Guardian Signature:_____Date: _____

Relationship to Student: _____

Nurse to Complete the Bottom Portion

Name of Medication _____

Reason for Medication _____

Form of Medication: Tablet/Capsule_____**Liquid**_____**Other**_____

Any special directions: **(scheduled dose to be given at school)**

Start (Date form received)

Date to discontinue _____ **July 30, 2025**