



Medication Authorization for Students

Student's Name: _____ **Date of Birth:** _____

School Year: _____ **Grade:** _____

To be completed by a Licensed Health Care Provider

It is necessary that the medication below be given during school hours to keep this student in optimum health, to help maintain maximum school performance and/or to sustain attendance.

Name of medication (one per form): _____

Generic substitution permitted or comparable brand is acceptable? **Circle one: YES / NO** Initials _____

Route: Circle One: TABLET CAPSULE LIQUID INHALER NEBULIZER PATCH DROPS OTHER: _____

Dosage: (amount to be given) _____

Time/Frequency: _____ **Or as needed every** _____ **hours**

Reason for medication: _____

Most common side effects: _____

Termination Date: _____ (Unless an earlier date is provided, medication orders remain valid throughout the current school year including summer programs and activities. All orders must be renewed at the start of each school year).

Authorization for student to self-administer medication: The student has been instructed in the treatment plan and self-administration of the medication and has demonstrated the knowledge and skill necessary to self-administer this medication. I have determined that adult supervision is not needed.

Student should be allowed to self-carry and administer this medication. YES / NO Initials: _____

Licensed Health Care Provider Signature: _____

Licensed Health Care Provider Printed Name: _____

Telephone Number: _____ **Date:** _____

To be completed by a Parent: please select the one authorization that applies to your child.

Parent permission for medication to be administered by the school staff:

I give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed healthcare provider. I hereby release the School Board, their agents, and employees from all liability that may result from my child taking the prescribed medication. I will furnish all medication and necessary supplies to the school. Prescription medications must be in a container with a pharmacy label with information that matches the above order. I understand that expired medications cannot be administered at school.

Parent Signature: _____ **Date:** _____

Parent permission for medication to be self-administered by their child:

I agree to the medication authorization as written by my child's health care provider. I request that my child be allowed to carry and self-administer the medication at school as prescribed by my child's health care provider. I understand that my child must carry this medication at all times and the school takes no responsibility for administration of this medication. I hereby release the School Board, their agents and employees from all liability that may result from my child taking this medication. My child is knowledgeable about this medication and how to self-administer it. My child understands that no other person can use this medication. I agree to ensure that the medication will have a pharmacy label that matches the order and is not expired.

Parent Signature: _____ **Date:** _____