



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

School Year \_\_\_\_\_ - \_\_\_\_\_

**STUDENT INFORMATION**

Student's Name: \_\_\_\_\_ School: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Wt.: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

\_\_\_\_\_ No known drug allergies \_\_\_\_\_ Allergies (please list) \_\_\_\_\_

**Over-The-Counter Medication Authorization**

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: \_\_\_\_\_

**PARENT AUTHORIZATION**

I authorize the school Nurse, the registered nurse (RN) or licensed practical nurse (LPN), to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

**Prescription Medication** must be registered with the School Nurse or Trained Medication Assistant. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

**Over the Counter Medication** must be presented to the School Nurse or Trained Medication Assistant. OTCs must be in the original, unopened, and sealed container. **OTC medication may not be kept for more than 2 weeks without written authorization from an authorized licensed healthcare provider.** Local Education Agency Policy for OTC medication must be followed.

Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_