



Medication Authorization Form: Day Students

STUDENT _____ Y.O.G. _____

D.O.B. _____ ALLERGIES _____

Note: Prescription medication must be in the original container indicating the following information: student, name, medication, dose, route, time to be administered, and healthcare provider.

Over-the-counter medications must be in the original container with clear labeling. If a student takes more than one medication, please fill out one form for each medication.

PARENT STATEMENT: I authorize the administration of medication to my child and request that the medication listed below be given to my child named above.

- I agree to provide the school/my child (if self-carry) with the medication.
- I understand that the medication must not be expired.
- I understand that in the absence of the school nurse, other trained staff may administer medication.
- I understand that as part of the provision of care between health providers, the school nurse may contact the health care provider or pharmacist regarding the administration of the medication and any other medications.
- I have reviewed, and will continue to review, my child's health plan, as applicable.
- I will notify the school immediately if the health plan and/or the medication is changed.
- I understand the school nurse may provide information to school staff who need to know about my child's health condition and rescue medication (as applicable) for safety.
- I understand that this medication will be destroyed per federal DEA requirements after the last day of school/enrollment.

Parent/guardian signature _____ Date _____

Printed name of parent _____

Home phone _____ Cell phone _____

Other medications your child is taking _____

HEALTHCARE PROVIDER STATEMENT: This medication is required during school hours to improve or maintain the health of the student. The nurse may contact me regarding this medication. The above-named child should receive prescribed medication for the following condition:

Medication name _____ Prescribed Dose _____

Dose at school _____ Time given at school _____

Beginning date of medication _____ Ending date _____

Possible side effects _____

Special Instructions* _____

Restrictions _____



The Healthcare Provider must complete this section for emergency medications that will be self-carried ONLY, e.g. inhaler, glucagon, epinephrine auto-injector (EpiPen), etc.

Student is allowed to possess and self-administer medication: _____
Provider's Initials

The student has the knowledge and competency to possess and self-administer medication.

Provider's Initials

Healthcare Provider Signature _____ Date _____
Printed Name _____ Phone _____
HealthCare Provider Address _____
HealthCare Provider Email _____

School Nurse Signature _____ Date _____
Phone: 207 282-3361 x 4465 / Fax: 207 391-6388
Email: deborah.prescott@thorntonacademy.org

To be completed by the School Nurse:

The School Nurse has evaluated and ensured the proper use of emergency medication.

Yes Date:

An Individual Health Plan has been created.

Yes Date: