ALABAMA STATE DEPARTMENT OF EDUCATION
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year _____-_____

STUDENT INFORMATION

Student's Name: _____ **School: _____**

Date of Birth: _____ **Age: _____** **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 theschoolNurse, 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 Medicationmust 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 medicationmust be followed.

Parent's/Guardian's Signature: _____ Date: _____ Phone: _____

Revised 04/2024