Farmington Municipal Schools Health Services
Medication Authorization Form

FORM INFO

Medications must be checked in and out by a parent/guardian to the health office. Medications may not be transported by students.

Your signature on this form authorizes other school personnel to supervise your child with self-administration of medication and/or to administer medication to your student when health staff may not be available.

A new form must be completed every school year, for each medication, whether it is prescription or non-prescription.

Parent/Guardian: Please complete information in this top section and sign authorization at the bottom of the page.

Student Name	**DOB**	**Age**	**Grade**	**Medication Allergies**

Prescriber Name	**Prescriber Phone**
Parent/Guardian Name	**Parent/Guardian Phone**
Emergency Contact	**Emergency Contact Phone**

Prescriber: Please complete Medication Information and Authorization below.

MEDICATION INFORMATION

Diagnosis: _____

Name of Medication: _____ **Dose:** _____

Time of Administration: _____ **Route:** _____

Duration of Administration: ☐ Entire School Year
☐ Specified Dates: _____ to _____

Special Instructions: _____

_____

_____

Options for Administration (select one or more):

☐ Student may self-administer under direct supervision of a designated, trained staff person.
☐ Student may self-administer without supervision.
☐ Administration by nurse or trained staff person.

AUTHORIZATION

Prescriber Signature: _____ **Date:** _____

Parent/Guardian Consent: I, the parent/guardian of the student listed above, hereby request that the medication listed above be given to my child according to the prescriber's instructions and school policy. I agree that the medication must be taken during school hours as directed by the prescriber. I grant permission for the school to exchange information with my child's prescriber as deemed necessary. I agree to furnish necessary medication in the original, pharmacy-labeled container, to provide replacement medication as necessary, and to provide a new prescriber's statement if there is ANY change in the medication, dosage, administration time, administration route, or special instructions regarding the medication. I understand that other designated personnel (other than the school nurse) may supervise my child with the administration of medication. I give my permission for the school to share the above information with school staff that need to know about my child's condition.

Parent/Guardian Signature: _____ **Date:** _____

I want to be notified any time a medication on this form is administered to my student ☐ Yes ☐ No

School Nurse Signature: _____ **Date:** _____

Revised: 03/2024