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** |
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| **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 and self-carry medication 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
I confirm student is capable to safely carry and properly administer above medication(s) ☐ Yes ☐ No
**If yes, see school nurse for additional paperwork**

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

Revised: 05/2025