Mustang Public Schools

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

One Medication per Form

Authorization and request for the administration of medication at school for prescription and/or non-prescription medication.

Student _____Birthdate _____Grade_____ School Year_____

School_____ Teacher_____ Date received_____

1. Reason for medication_____

2. Name of medication_____

3. Dosage_____ Parent Initials/Date_____

4. Time to be administered_____

5. Duration (week, month, indefinite, etc.)_____

6. Side Effects: None Expected_____ Specify_____

7. Form of medication/treatment: Tablet____ Liquid____ Inhaler____ Injection____ Nebulizer____ Other_____

8. Special storage requirements: None _____ Refrigerate _____

TO BE COMPLETED ONLY BY THE PARENT/GUARDIAN: I hereby request and give my permission for the above named school to administer the medication prescribed on this form. Prescription medication must have the pharmacy label attached and must match the written prescriber order. “Over the counter medication” must be in the original container. All medication must be brought to school by an adult. Substances not approved by the FDA will not be stored nor administered by school personnel. I further understand that I will be responsible for picking up any remaining medication at the end of the school year; medication will NOT be sent home with students. Any medication remaining after the school year has ended will be discarded utilizing proper procedure. The school nurse may consult with the prescriber regarding this prescription. Changes to the time and/or dosage of the medication require written authorization from the licensed prescriber and parent/guardian.

I understand and acknowledge the above statement. _____

Parent Signature/Date

Revised 4/28/26

Student Name_____ **DOB**_____

Medication Side Effects or Special Instructions_____

Date	Medication	# Received	# Returned	Pharmacy	Rx #	Initials
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Progress Notes/Communication

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