**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 the school Nurse, 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 Medication** must 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 medication must be followed.

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

Revised

04/2024