Hazelwood School District
"A Culture of High Expectations and Excellence!"

Dr. Bonita Jamison, Superintendent

PARENT AUTHORIZATION FOR PRESCRIPTION MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS
School Year 2026-27

The following section is to be completed by the PARENT:

Child's Name (Last)_____(First) _____

Sex_____Birth Date _____

Home Phone_____ Emergency Phone _____

My son/daughter has the following food or drug allergies: _____

_____I am requesting that, during school hours, the school nurse or designated person administer this prescription medication according to the directions on the medication's prescription label or the current physician order, whichever is most recent.

I understand that the information is confidential under the Family Educational Rights and Privacy Act (FERPA), and that school personnel who need to know have access to it. I agree to coordinate with school personnel if any questions arise.

I understand I may cancel this request at any time and/or retrieve the medication from the school at any time. If I do not pick it up, I give permission to the school nurse to destroy any medication remaining at the end of the school year.

Parent/Guardian Signature:_____Date: _____

Relationship to Student: _____

Nurse to Complete the Bottom Portion

Name of Medication _____

Reason for Medication _____

Form of Medication _____ Tablet/Capsule _____ Liquid _____ Inhaler_____ Injection _____

Other (explain) _____

Instructions (scheduled dose to be given at school)

Start (Date form received) _____

Date to discontinue _____ July 30, 2027

Revised 4/2026