



**ALABAMA STATE DEPARTMENT OF EDUCATION
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION**

School Year _____ - _____

STUDENT INFORMATION

Student's Name: _____ School: _____
Date of Birth: _____ Age: _____ Weight.: _____ 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 the 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: _____