



Authorization for Administration of Medication at School

Parents/guardians asking school staff to give medications to their student must provide written permission every school year. Prescription medication requires written authorization of both the student's physician/licensed prescriber and the parent/guardian every school year.

Student Name: _____ Date of Birth: _____ Grade: _____

Condition	Medication	Dose	Time	Route	Possible Side Effects
1.					
2.					
3.					

Other consideration/directions: _____

Start date: _____ Stop date: _____

All authorizations expire at the end of the school year or following the summer school session.

Signature of Physician/Licensed Prescriber

Print Name of Physician/Licensed Prescriber

Date

Clinic Name _____ Phone _____ Fax _____

Parent/Guardian Authorization

- 1 I request the above medication(s) be given during school hours, including field trips, as directed by parent/guardian and/or my student's physician/licensed prescriber
- 2 I will notify the school of any change in the medication(s), i.e. change in dose, medication is stopped, etc
- 3 I give permission for the school nurse to communicate as needed with school staff about the student's health condition and the action of the medication(s)
- 4 I give permission for the school nurse to consult with the student's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s)
- 5 I give permission for the medication(s) to be given by school personnel as delegated, trained, and supervised by the licensed school nurse
- 6 I request that the medication be given during SLP non-school hours/days programming (ie Kids Place/Enrichment Programs) I am responsible for training the staff and supplying medication I understand the school nurse is not available during this time ☐ Yes ☐ No

Note: Medication must be supplied in the original/prescription bottle

Parent/Guardian Signature

Relationship to Student

Date

Daytime Phone

Return to Health Office

Health Office Staff Use Only:

Med. Expiration date _____



Medication in Health Office



Documented in Health Record

For internal use only

Student Name: _____ Date of Birth: _____

Medication: _____ Grade: _____

Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9
10	10	10	10	10	10	10	10	10	10
11	11	11	11	11	11	11	11	11	11
12	12	12	12	12	12	12	12	12	12
13	13	13	13	13	13	13	13	13	13
14	14	14	14	14	14	14	14	14	14
15	15	15	15	15	15	15	15	15	15
16	16	16	16	16	16	16	16	16	
17	17	17	17	17	17	17	17	17	
18	18	18	18	18	18	18	18	18	Aug
19	19	19	19	19	19	19	19	19	19
20	20	20	20	20	20	20	20	20	20
21	21	21	21	21	21	21	21	21	21
22	22	22	22	22	22	22	22	22	22
23	23	23	23	23	23	23	23	23	23
24	24	24	24	24	24	24	24	24	24
25	25	25	25	25	25	25	25	25	25
26	26	26	26	26	26	26	26	26	26
27	27	27	27	27	27	27	27	27	27
28	28	28	28	28	28	28	28	28	28
29	29	29	29	29	29	29	29	29	29
30	30	30	30	30		30	30	30	30
	31		31	31		31		31	31

Medication Given By:

Signature/Initials

Controlled Substance Count:

Date	Initials	# Rec.	# Sent	Date	Initials	# Rec.	# Sent
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Abbreviations:

A= Absent
AW= Accidentally Wasted
FT= Field Trip
H= Hold
NG= Not Given

NMA= No Medication Available
PG = Parent Gave Medication

inaaier brought in:

Date/Initials: _____

Circle one: New/Used or Partially Used