AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION IN SCHOOL

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

Name of Medication	Dose	Route -Oral -Topical -Other	Time(s) To Be Given:	Reason	Prescriber /Clinic	Additional Instructions/Info:

- **For altered school schedules, the following medication guidelines will apply unless you indicate otherwise.**
  - One-hour delay: doses will be given as usual, with minor modifications in timing, if needed.
  - Two-hour delay: medications scheduled before 10 a.m. will not be given; other doses will be given as above.
  - Early outs: medications scheduled to be given after 2 pm or later will not be given.

PARENT/GUARDIAN AUTHORIZATION

I request designated school personnel to administer the medication as prescribed by the above prescriber. I certify that I have the legal authority to consent to medical treatment for the student named above, including the administration of medication at school. (I understand that at the end of the school year, an adult must pick up the medication, otherwise, it will be discarded.) I authorize the school nurse to communicate with the health care provider.

Parent/Guardian Signature: _____ **Date:** _____

- A new form is needed for all changes in medication, dose, or time.
- The medication shall be brought to school by a parent/guardian or responsible adult.
- Prescription medications must contain the following:
  - Placed in its original container that is currently dated and labeled by the pharmacy.
  - Labels should contain the student's name, prescriber, name of medication, dose, route, and frequency and duration of medication.
  - Unless otherwise specified, the medication order is valid for the entire school year.
  - Expired and discontinued medication not picked up by the last day of school will be destroyed

TO BE COMPLETED BY SCHOOL

Date form received at school: _____ Received by: _____