AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION ADMINISTRATION FORM

STUDENT NAME__________________________ **GRADE/POD**___________ **SCHOOL** ___________

NON-PRESCRIPTION MEDICATION:
Parents of students requesting non-prescription (over the counter) medication to be given to their child during school hours by school staff are required to provide the school with the following information: 1. A signed parent consent and 2. Medication must be supplied in the original packaging.

- ☐ ***Please Note** IF these meds are not picked up at the end of the year we will destroy them if expired.*** ____________ *(Parent Initials)* *Expiration Date of Medication*__________________

Medication	Dose	Time	Route	Reason for Medication or Medical Condition

Start date: __________________________ Stop date: ______________________________
(All authorizations expire at the end of the school year or following the summer school session.)

Parent/Guardian Authorization

1. I request that the above prescription medication be given during school hours as ordered by my child's physician/licensed provider. I also request the medication be given on field trips, as prescribed.
2. I will notify the school of any change in the medication, (i.e. dosage change, medication is stopped, etc.).
3. If medication is non-prescription, this signature also gives permission to administer that medication.
4. I give permission for the medication to be given by school personnel as delegated, trained, and supervised by the school nurse.
5. Legally, I may refuse to sign for the medication. If I refuse to sign, we will not be able to administer the medication at school.
6. This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

________________________ ________________ ____________________
Parent/Guardian Signature Date Relationship to Student

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and medication(s) my child is taking.
2. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) my child has.
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.

________________________ ________________ ____________________
Parent/Guardian Signature Date Relationship to Student

AUTHORIZATION FOR PRESCRIPTION MEDICATION ADMINISTRATION FORM

STUDENT NAME__________________________ **GRADE/POD**________________ **SCHOOL** ____________

PRESCRIPTION MEDICATION:
Parents of students requesting prescription medication to be given to their child during school hours by school staff are required to provide the school with the following information: 1. The Doctors' signed order 2. A signed parent consent 3. Medication must be supplied in the original pharmacy labeled bottle.

- ☐ ***Please Note** IF these meds are not picked up at the end of the year we will destroy them if expired.*** _____________ *(Parent Initials)* *Expiration Date of Medication*____________________

Physician/licensed prescriber's order for Medication Administration by School Personnel

Medication	Dose	Time	Route	Reason for Medication or Medical Condition

Other considerations/directions:

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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 Address	**Phone**	**Fax**

Parent/Guardian Authorization

7. I request that the above prescription medication be given during school hours as ordered by my child's physician/licensed provider. I also request the medication be given on field trips, as prescribed.
8. I will notify the school of any change in the medication, (i.e. dosage change, medication is stopped, etc.).
9. If medication is non-prescription, this signature also gives permission to administer that medication.
10. I give permission for the medication to be given by school personnel as delegated, trained, and supervised by the school nurse.
11. Legally, I may refuse to sign for the medication. If I refuse to sign, we will not be able to administer the medication at school.
12. This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

______________________	______________________	______________________
Parent/Guardian Signature	Date	Relationship to Student

Permission for Release of Information

4. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and medication(s) my child is taking.
5. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) my child has.
6. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.

______________________	______________________	______________________
Parent/Guardian Signature	Date	Relationship to Student