*District Logo*
*Sample*

Appendix D

# Medication Authorization Form

STUDENT _____ GRADE _____

SCHOOL _____ BIRTHDATE _____ *place student photo here*

ALLERGIES_____

*Note: Prescription medication must be in the original container indicating the following information: student name, medication, dose, route, time to be administered, and healthcare provider. Over-the-counter medications must be in the original container with clear labeling.*

PARENT STATEMENT: I request that the medication listed below be given to my child named above.

• I understand that medication must not be expired.

• I understand that in the absence of the school nurse, other trained school staff may administer medication.

• I understand that the school nurse may contact the health care provider or pharmacist regarding this treatment.

• I will notify the school immediately if the medication is changed.

• I understand that this medication will be destroyed per federal DEA requirements unless picked up by the end of the last student school day of this year.

Parent/guardian signature_____Date_____

Home phone _____ Emergency phone_____

Other medications your child is taking_____

HEALTHCARE PROVIDER STATEMENT: This medication is required during school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication. The above-named child should receive prescribed medication for the following condition: _____

Medication name_____ Prescribed dose_____ Dose at school _____

Time given at school_____ Beginning date of medication_____ Ending date_____

Possible side effects_____ Special instructions_____

Healthcare provider signature _____ Date _____

Printed name _____Phone_____

Healthcare provider address_____

Healthcare provider email _____

School nurse signature_____Date_____

Phone _____ Fax _____Email _____

Revised 4/2022