AUTHORIZATION FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

Parents please note:

1) **Over-the-counter** medications require a **parent/guardian signature**
2) **Prescription** medications require a **parent/guardian signature AND physician's signature**
3) All medications must be in the **original, labeled bottle**
4) The school **does NOT supply** any medication

Student's Name: _____ **Grade**: _____ **DOB**: _____

Teacher: _____ **School Year**: _____

Medical Condition	Medication	Dose	Time	Route	Possible Side Effects

Other Considerations/Directions: _____

Parent/Guardian Authorization

1) I request that the above medication be given during school hours
2) I release the school personnel from liability in the event adverse reactions result from taking the medication
3) I will notify the school nurse and/or health assistant of any change in the medication
4) I give permission for the school nurse and/or health assistant to communicate with school personnel about the student's health condition and action of the medication as needed.
5) I give permission for the school nurse and/or health assistant to consult with the student's physician regarding any questions/concerns that may arise with regard to the medication or medical condition being treated by the medication
6) I give permission for the medication to be given by designated school personnel as delegated by the school nurse

_____ My child may carry his/her inhaler and or epi-pen

_____ Medication should be sent along with school personnel on field trips

Parent/Guardian Signature: _____ Date: _____

Physician/Licensed Prescriber Authorization

I have prescribed the medication listed above for this child and request it to be given during school hours by school personnel.

Physician Signature: _____Date: _____

Clinic: _____ Phone#: _____ Fax#:_____