

**PARENTAL AUTHORIZATION FOR ADMINISTRATION OF
PRESCRIPTION MEDICATION**

_____/_____/_____
Student's Name (Last), (First), (Middle) **Birth**day **School** **Date**

School medications and health services are administered following these guidelines:

- Parent has provided a signed, dated authorization to administer medication and/or provide the health service.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student's name, name of the medication, directions for use, and date.
- Authorization is renewed annually and immediately when the parent notifies the school that changes are necessary.

Medications/Health Care **Dosage** **Route** **Time at School**

Administration Instructions

Special Directives, Signs to Observe and Side Effects

_____/_____/_____
Discontinue/Re-Evaluate/Follow-up Date

Prescriber's Signature

_____/_____/_____
Date

Prescriber's Address

Emergency Phone

I request the above named student carry medication at school and school activities, according to the prescription, instructions, and a written record kept. Special considerations are noted above. The information is confidential except as provided to the Family Education Rights and Privacy Act (FERPA). I agree to coordinate and work with school personnel and prescriber when questions arise. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

Parent's Signature

_____/_____/_____
Date

Parent's Address

Home Phone

Additional Information

Business Phone