



AUTHORIZATION FOR MEDICATION FORM

Dear Parent and Medical Providers:

PLEASE READ THE ATTACHED MEDICATION ADMINISTRATION GUIDELINES ON THE BACK OF THIS FORM.

MEDICAL PROVIDERS PLEASE COMPLETE THE FOLLOWING:

Student Name _____

Name of Medication _____ Dosage _____

Route Given _____ Time(s) _____

Start Date _____ End Date _____

Student's diagnosis and reason for medication _____

Adverse reactions or side effects _____

Additional Comments _____

Students may self carry/medicate (grades 6-12) only if authorized by the medical provider and parent/guardian.

This student is both capable and responsible for self-administering this medication according to school policy:
 No **Yes - Supervised** **Yes - Unsupervised** **Medical Provider Initials** _____

Student is authorized to self carry this medication:
 No **Yes** **Parent/Guardian Initials** _____

Please indicate if you have provided additional information as an attachment.

I certify this student requires such medication be given during school hours and that no alternative schedule is medically advisable.

Medical Provider Signature _____ **Date** _____

Print Name _____ Phone _____

Address _____

City/State _____ Zip Code _____

Parent/Guardian Signature _____ **Date** _____



MEDICATION ADMINISTRATION GUIDELINES

1. **A written authorization and order completed and signed by the student's medical provider and a parent/guardian is required before any medication can be given at school.**
2. **Medications include:**
 - Prescription medications
 - Over-the-counter and herbal medications
 - Topically applied ointments
 - Eye or ear drops
 - Inhalers
 - Nasal Sprays or mists
3. **The physician order must be complete, dated and written to cover the entire school year or for a specific length of time as determined by the medical provider.**
4. **Medication orders must be renewed annually or if a change in dosage occurs.**
5. **Parents/guardians are responsible for providing medication and any supplies needed. Medication that arrives at school in any form other than the one it was dispensed in by the pharmacy (medication that has been crushed, divided or mixed by the parent/guardian) will not be given.**
6. **The school will only administer prescribed medication that arrives at school in its original form and with a pharmacy label that includes:**
 - Name of Student
 - Name of Medication
 - Name of Physician
 - Dated
 - Strength of medication
 - Dosage
 - Route to be given
 - Frequency or time of administration
 - Special instructions for storage or precautions
7. **The information on the pharmacy label must match the medical provider's order on the Authorization for Medication Form.**
8. **Self possessed and administered medication must be in its original container with a pharmacy label. Only one day's dose may be carried by the student.**