# Farmington Public School District

## AUTHORIZATION FOR MEDICATION FORM

Dear Parent and Physician:

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

**PHYSICIAN PLEASE COMPLETE THE FOLLOWING:**

Student Name_____

Name of Medication_____Dosage_____

Route Given_____Time_____

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 physician and parent/guardian.**

-This student is both capable and responsible for self-administering this medication according to school policy

**___No ___Yes-Supervised ___Yes-Unsupervised Physician 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.**

**Physician 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 physician 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 physician.**

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 physician'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.**