Helping students become the fully functional persons God created them to be.

Prescription Medication Prescriber/Parent/Guardian Authorization

STUDENT INFORMATION

Student's Name ____

Grade__________ Teacher____ School Year __________________

List any known drug allergies/reactions ____

Height (inches) _____________________ Weight (lbs) _________________________

PRESCRIBER AUTHORIZATION

Name of Medication _____________________________________ Reason for Taking (optional) ____________________

Dosage _________________________________ Route _______________ Frequency/Time(s) to Be Given __________

Begin Medication _______________________________ Stop Medication _______________________________________
Date Date

Special Instruction:
Does medication require refrigeration? Yes No
Is the medication a controlled substance? Yes No
Is self-medication permitted and recommended for this student? Yes No
If asthma inhaler or emergency medication, do you recommend this medication be kept **"on person"** by the student? Yes No

Potential Side Effects/Contraindications/Adverse Reactions ____

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____

Treatment Order in the event of an adverse reaction: (Attach additional sheet or use the back of this form if necessary)

____

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____ ____________________ __________________________
Signature of Prescriber **Date** **Phone Number**

Parent Authorization

I authorize the Director to delegate to school personnel the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorized the Director or her designee to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the Director or her designee. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate.

____ ________________________________
Signature of Parent/ Guardian/ Social Worker **Date**

I authorized and recommend self-medication by my child for the above medication.

____ ________________________________
Signature of Parent/ Guardian/ Social Worker