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| SAMPLE:  INSERT LOGO/SAU/SCHOOL NAME | MEDICATION AUTHORIZATION  SCHOOL YEAR \_\_\_\_\_\_ |

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| **Name** | Date of Birth | Grade | *Place student photo here* |
| Allergies | | |
| *Note: Prescription medication must be in the original container indicating the following information: student name, medication, dose, route, time to be administered, and healthcare provider. Over-the-counter medications must be in the original container with clear labeling.*  PARENT STATEMENT: I request that the medication listed below be given to my child named above.  • I understand that medication must not be expired.  • I understand that in the absence of the school nurse, other trained school staff may administer medication. • I understand that the school nurse may contact the health care provider or pharmacist regarding this treatment.  • I will notify the school immediately if the medication is changed.  • I understand that this medication will be destroyed per federal DEA requirements unless picked up by the end of the last student school day of this year.  • I permit the school nurse to share information about my student’s health with appropriate school and medical personnel for my student’s ongoing safety at school.   |  |  |  | | --- | --- | --- | | Parent/guardian signature | Date | Printed name | | Home/cell phone | | Emergency number | | Other medications taken at home | | |   HEALTHCARE PROVIDER STATEMENT: This medication is required during school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication. The above-named child should receive prescribed medication for the following condition:   |  |  |  | | --- | --- | --- | | Medication name | Dose | Route | | Time | Beginning date | Ending date | | Possible side effects | | Special instructions | | Prescriber signature | | Date | | Printed name | | Phone | | Address | | | | School nurse signature | | Date | | Printed name | | School | | | | |