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

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |

 |