Authorization for In-School Medication

Grade_____Date of Birth_____

I give permission for _____to be given the following medication by the School Nurse or other unlicensed trained school personnel:

Name of Medication_____

Dosage of Medication_____

Date/s to be given_____

Time to be given/intervals between doses_____(Example: 12pm, every 4 hours as needed)

Route of Medication _____ (example: oral, in eye, ear, inhaler, to skin)

Purpose of Medication_____

Other Instructions_____

***Prescription medication*:** The medication must be in the original container with a current pharmacy label that includes: student name, medication, dose and time, date of prescription and the physician's name. Medication can only be given as instructed on the label.

***Over the Counter medication*: (Such as Cough Medicine, Cough Drops, Eye Drops (Tylenol and Ibuprofen if you prefer to send your own) ETC)** The medication will be provided by the parent, be in the original container, and labeled with the student's name, dose and time. Medication can only be given as directed on the bottle for age and dose. Any changes in the manufacturer's recommendation will require a written order from the physician.
Any medication not properly labeled or stored cannot be given at school. No medication can be given without completion of this form. Parents will be notified if requested on form when child takes an "as needed" medicine.
All medications must be stored at the main office (cough drops may be kept in room if the Teacher permits). Medications for self-management of a condition such as asthma/allergies or diabetes may be kept by student if the following requirements have been met: Written request/authorization of the student's parent/guardian **and** written authorization of the student's physician. Specific forms are available for this.

I am not aware of any side effects, adverse reactions or any other problems my student is experiencing with this medication. I understand that I am primarily responsible for monitoring the effects of this medication. The School Nurse has my permission to contact Dr. _____ or his designee at _____(phone number), regarding this medication.

_____ _____
Date and Parent/Guardian Signature

All over the counter medications will be returned with student at the end of the school year unless you contact the school nurse. Parents must pick up prescription medications in Main Office.