Parent Authorization for Medication Administration

Student name: _____Date of Birth:_____

Parent/Guardian name (print): _____

Telephone number Home/Cell : _____Work: _____Emergency:_____

Other person(s) to be notified in case of a medication emergency: _____

Name: _____Telephone Number: _____

My child is currently receiving the following medications (to be completed if not in violation of confidentiality):

Any special directions, signs to observe, side effects:

My child has the following food or drug allergies:

Date to discontinue medication:_____ Follow up visit to prescriber: _____

I am requesting the school nurse or designated school personnel to administer the medication prescribed by:

_____ to _____.

(Licensed prescriber) (*Student)*

I am requesting that the school nurse or designated person administer this over-the-counter (OTC), non-prescription drug according to the manufacturer's directions. (Initial) ☐

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate ☐

I request the above student receive this medication according to the prescription or parental request for OTC drug, and any special instructions. I understand the information is confidential according to the Family Rights and Privacy Act (FERPA), and school personnel, needing to know, have access to this information. I agree to coordinate and work with school personnel and the prescriber if questions arise.

I understand I may cancel this request at any time, and/or retrieve the medication from the school at any

time. I understand the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/guardian signature: _____ Date: _____

Relationship to student: