Authorization To Give Medication At School (Prolonged Time Period)

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page.

Student's Name: _____

Teacher: _____ Grade: _____

I request that _____School, through the principal or designee supervise/assist in the administering of mediation to my child according to instructions the instructions below. I understand that:

- _Medications must be in the original labeled container (no baggies foil, etc.) Pharmacies can provide a duplicate labeled container with only the school doses.
- _Parent/guardian must provide special instructions, as well as the medication and related equipment to the principal or clinic personnel.
- _It will be the responsibility of the parent/guardian to inform the school of any changes. New medications or new doses will not be given unless a new form is competed and a newly labeled container is provided.
- _All medications will be taken directly to the office/clinic by the parent/guardian.
- _Unused medication will be disposed of unless picked up within one week after medication is discontinued.

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Name of medication: _____

Dose: _____ Route (by mouth, topical, etc.): _____

Time(s) to be given: _____ Stop medication on: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize the school personnel, employees and officials of the _____ School District to assist my child in taking prescribed medication according to district policy and I release them form any liability for administering this medications I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

_____ _____

Parent/Legal Guardian *Date*

Home Phone _____ Work Phone _____ Pager/Cell Phone _____

To be completed by healthcare provider for prescription medications given for more than two weeks.

Condition/Illness Requiring Medication: _____

Possible Side Effects if any:_____

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Signature of Healthcare Provider *Date*