**FOR PRESCRIPTION MEDICATIONS SCHOOL YEAR \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATION AUTHORIZATION/ADMINISTRATION FORM**

This form must be completed by BOTH the Health Care Provider and Parent/Guardian.

1. A signed physician form is required for any prescription medication given during the school day.
2. Over-the-counter medication prescribed with the following conditions:
3. For a chronic condition (ex. migraine headaches, allergies, GI disorders, etc)
4. For a period lasting longer than 2 weeks
5. To be dispensed contrary to the package directions (ex. adult dose for a child, etc)

**HEALTH CARE PROVIDER SECTION**

STUDENT’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

DIAGNOSIS/REASON FOR MEDICATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOSAGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FREQUENCY/TIME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIDE EFFECTS/RESTRICTIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THE ABOVE NAMED STUDENT: \_\_\_\_\_IS \_\_\_\_\_IS NOT CAPABLE OF SELF-ADMINISTERING THEIR OWN MEDICATION.

 HE/SHE: \_\_\_\_\_MAY \_\_\_\_\_MAY NOT CARRY THEIR OWN INHALER OR EPIPEN.

HEALTH CARE PROVIDER STAMP:

HEALTH CARE PROVIDER SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_

**PARENT SECTION**

**\*A parent/guardian will deliver all medication(s) directly to the school nurse.**

**\*All medications must be stored in their original pharmacy or manufacturer labeled container.**

**\* The school nurse will verify medication quantity and accuracy of emergency contact information each time a medication is delivered to the school.**

**\* Prescription medication will only be given when appropriate documentation is completed by the provider and parent.**

**I hereby request that my child be assisted in taking the above medication(s) as ordered by their provider. I release SAU63 and all its employees form any and all liability for any side effects that may occur as a result of this request.**

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_