

## SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

## STUDENT INFORMATION

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School Haleyville Middle School Grade \_\_\_\_\_ Teacher \_\_\_\_\_ School Year \_\_\_\_\_

List any known drug allergies/reactions \_\_\_\_\_ Height (inches) \_\_\_\_\_ Weight (lbs) \_\_\_\_\_

## PRESCRIBER AUTHORIZATION

Name of Medication \_\_\_\_\_ Reason for Taking \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_ Frequency/Time(s) to be given \_\_\_\_\_

Begin Medication \_\_\_\_\_ Stop Medication \_\_\_\_\_  
Date Date

## Special Instructions:

Does medication require refrigeration? Yes  No Is the medication a controlled substance? Yes  No Is self-medication permitted and recommended for this student? Yes  No If yes, do you recommend this medication be kept "on person" by the student? Yes  No 

Potential Side Effects/Contradictions/Adverse Reactions \_\_\_\_\_

Treatment Order in the event of an adverse reaction: \_\_\_\_\_  
(Attach additional sheet or use the back of this form if necessary)

I hereby affirm that this student has been instructed in the proper self-administration of the prescribed medication (s).

Signature of Prescriber (please print) \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

## PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to delegate to unlicensed school personnel the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the principal, his/her designee, or the school nurse. It must be in the original, unopened, sealed container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

## SELF-ADMINISTRATION AUTHORIZATION

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_