SISTERS SCHOOL DISTRICT

Authorization for Medication Administration by School Personnel

Student Name:_____ Date of Birth:_____ Grade:_____

Teacher: _____ School:_____

I am giving trained school personnel permission to administer medications to my child per the following (Parent or Physician please complete):

Medication: _____ □ Non Prescription

Dose (how much):_____ □ Prescription #_____

Frequency (how often):_____

Route (check one): By: Mouth__ Ear__ Eye__ Nose__ Skin__

Time:_____

Duration: Start date:_____ End Date:_____

Reason for Medication:_____

_____

Special Instructions:_____

_____

ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABELING

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

Parent/Guardian Signature: _____ Date:_____

(This authorization applies only to the medication listed above and for the duration of treatment or school year). This also authorizes an exchange of information, as necessary, between the school nurse, appropriate personnel, and/or my child's health provider.

PHYSICIAN DIRECTION

(required in writing OR on pharmacy label for all prescription medications)

I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate. Special instructions including adverse reactions and action require:

_____

_____

_____ _____

Physician's Name (Please print/stamp) Address Zip Code

_____ _____

Physician's Signature Phone Effective Date