Over the counter / prescription medication authorization

Student: _____
Date of birth: _____
Grade: _____
School Year: _____

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for my student to receive the following medications during school hours according to standard school policy and in accordance with the following physician's instructions.

(Check appropiate spaces)

_____ The following **over- the - counter** medications must be kept for my student's use which will include original manufacturer's label with dosage instructions and length of time to be dispensed.

_____ The following **prescription** medications in the original pharmacy container prescription label intact and current dosage indicated.

Parent/guardian signature: _____
Relationship: _____
Date: _____

Name of Medication: _____
Reason for medication (optional) _____
Form of medication/treatment: Tablet/Capsule Inhaler Injection Nebulizer Other
Instructions (Schedule and dose to be given at school): _____
_____
Applicable dates: _____
Restrictions and/or possible side effects: _____
_____
Special storage requirements: _____
Is this student both capable and responsible for self-administering this medicine: yes no
(medicine should still remain in office area) (circle one)
Any additional information: _____
_____

PRESCRIPTION MEDICATION MUST HAVE PHYSICIAN OR AUTHORIZED PRESCRIBER SIGNATURE

Physician's signature _____
Physician's name: _____
Address: _____
Phone number: _____
Date: _____

MEDICATION IN SCHOOL

The school should be informed of all student health problems that require medication.

ALL MEDICATIONS MUST BE KEPT IN THE OFFICE AREA. Students should not have any type of medication, **prescription or over-the-counter**, on their person, in their backpack or in their locker. The exception being asthma inhalers and an Epi-pen which both require a prescription and the parental consent form to be signed and on file with the school office.

OVER –THE-COUNTER medications that may be periodically needed by the student during the school year and **prescription medication** for a student are to be kept in the original container/package with the pharmacy Label and student's name affixed.

The school cannot distribute any **prescription medication** without a medication form that has been filled out and signed by a parent/guardian and physician.

The school cannot distribute any **over–the-counter** medication without a medication form that has been filled out and signed by a parent/guardian.

Any medication(s) that a student may require during the school day should be brought to the office by a parent or guardian.

PLEASE COMPLETE THE FORM ON THE REVERSE SIDE