Authorization for Medication Administration at School

School year _____
School _____
Fax _____

1. This form is necessary for all prescription and non-prescription medication stored at school.
2. There must be a valid health reason which requires school staff to give this medication at school.
3. ***A new authorization form must be submitted each school year and is subject to approval.***
4. The parent/guardian should deliver the authorization form with the medication to the school office.
5. The medication should be in the original container and be unexpired.
6. For split tablets, medication must be split by a pharmacist or parent/guardian before bringing it to school.

PARENT/GUARDIAN to complete this section:

Student _____ DOB _____ Grade _____

Medication requested (one medication per form) _____

- I request that an authorized staff member assist my student in taking this medication as ordered by the provider.
- I will keep track of the expiration date and replace the medication before it expires.
- I understand that leftover medication will be discarded at the end of the school year if not picked up.

Parent/guardian printed name _____ Phone _____

Signature _____ Date _____

LICENSED HEALTHCARE PROVIDER (LHP) to complete this section: (avoid medical abbreviations)

Name of student _____

Condition being treated _____

Medication (one medication per form) _____

Dose (no range dosing) _____

Route _____

Time**/**frequency to be given at school _____

Possible side effects _____

Inclusive dates: ❑ Current school year (default if neither box checked)

❑ Less than current school year _____ _____
Start Date End Date

As the LHP, I verify there is a valid health reason which requires school staff to give this medication at school.

LHP printed name _____ Phone _____

Address _____ Fax _____

Signature _____ Date _____
MD, DO, ND, DMD, DPM, PA, ARNP, CNM