

Appendix 5

Authorization for the Administration of Prescribed Medication

Part I – To be completed by Parent/Guardian (Please type or print)

Student's Name: _____ Date of Birth: _____
M D Y

M.H.S.C. # _____ P.H.I.N. # _____

Emergency Contact: _____ Telephone _____

Relationship to Student:

I hereby request and authorize the school to administer the prescribed medication to my daughter knowing that:

- Medications presented to a school that are not prescription medication cannot be administered by school staff.
- The parent/guardian or designated adult is responsible for the delivery and supply of the medication. If requested, pharmacies will provide two original pharmacy labeled containers.
- The medication container must have the dispensing instructions noted on it and must have official label of the pharmacy.
 - o Name of the student
 - o Name of the prescribing physician
 - o Name of pharmacy
 - o Name of medication
 - o Dose
 - o Frequency and method of administration
 - o Date the prescription was filled
- It is the responsibility of the parent/guardian to notify the school in writing of any changes in dosage or time of administration of medication.
- The designated employee (or alternate) is to administer the prescribed medication.
- Authorization must be renewed annually with student registration or upon change in medication.

I also certify that the first dosage of the medication was given at home and was well tolerated. School personnel are authorized to contact the physician/pharmacist regarding any questions as to the administration of the medication.

Parent/Guardian Signature

Date

School Use Only

Staff Designate who will administer medication

Date Trained(If Required)

Training (If Required) Provided by _____

Signature of Principal

Date

Appendix 6

Authorization for the Administration of Prescribed Medication

Part II – To be completed by attending physician (Please type or print)

Student's Name: _____ Date of Birth: _____ \ _____ \ _____
M D Y

Address: _____

Physician's Name: _____ Telephone # _____

Medication Prescribed	Method of Administration	Dosage	Time
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_____	_____	_____	_____
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Start Date _____ End Date _____

Specific storage requirements

Side effects to watch for and actions required if these side effects are observed

Physician's Signature

Date