PARENTAL AUTHORIZATION AND CONSENT FORM FOR THE ADMINISTRATION OF MEDICATIONS TO STUDENTS

I hereby request that my child, ___________________________ Birth date: ______________ be permitted to receive the medication prescribed by __________________________________________.
Prescriber’s phone number is: __________________________________________.

Child’s Diagnosis: ______________________________________________________________________

Name of Medication: _____________________________________________________________________

Dosage: ___________________________ Time and date to be given: _____________________________

Special Instructions: _____________________________________________________________________
_____________________________________________________________________________________

The medication is to be furnished by parent/guardian and is to be correctly labeled in the original container from the pharmacy or manufacturer. The prescription label should include the child’s name, name of the medicine, the amount to be given, time of day to be taken, date, and the prescriber’s name. If any of the above information changes, the parent/guardian needs to submit a revised statement from the prescribing health care provider.

Date: ___________________________ Signature: ____________________________________________
Parent or Guardian

Home telephone number: ___________________________ Work telephone number: ___________________________

Notes:
1. Only medications which dosage schedules cannot be adjusted for before or after school hours should be given during the school day.
2. Only medications prescribed by an authorized health care provider will be given in school. This means medicines such as headache, stomach, cold, or cough remedies will not be given without a written order from an authorized health care provider.
   * Exception to the above: Secondary students (grade 6 -12th) may be given Acetaminophen 325 – 650mg orally every four to six hours or Ibuprofen 200 - 400mg orally every four to six hours at school with parental permission. If a student requires the above medication more than five times during a school year, a written order from an authorized health care provider will be required for additional doses. Cough drops and antacid (Tums/Rolaids) may be given to secondary level students with parental permission only.
3. Medications need to be delivered to and picked-up from school by the parent/guardian or an adult designated by the parent/guardian and need to come in the original prescription bottle or manufacturer packaging.
4. Please call the school nurse whenever you have questions about medications.

School Nurse Signature ___________________________ Date ___________________________