

AUTHORIZATION FOR PRESCRIPTION MEDICATION ADMINISTRATION

TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name _____ Date of Birth _____

Parent/Guardian _____ Home phone _____

Work phone _____

Cell phone _____

Other person to be notified in case of medication emergency:

Name _____ Home phone _____

Work phone _____

Cell phone _____

My son/daughter may need to receive the following medications during the school day:

My son/daughter has the following food or drug allergies:

I consent to have the school nurse or school personnel designated by the school nurse administer the medication prescribed by:

_____ to _____
Licensed Prescriber Student's Name

I give permission for my child to self-administer medication, if the school nurse determines it is safe and appropriate. Yes _____ No _____

I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.

I understand I may retrieve the medication from the school at any time: however, the medication will be destroyed if not picked up within one week following the termination of the order or one week beyond the close of school.

Parent/Guardian signature _____ Date _____

Relationship to student _____