# Medication Authorization Form

**Valid For The Following School Year** _____

**ALL PRESCRIPTION MEDICATIONS REQUIRE A PARENT AND PHYSICIAN'S SIGNATURE**

Student Name: Last_____ First_____Grade:_____

Parent Name: Last_____First_____

Address_____

City_____, State_____, Zip_____ Phone_____

**SECTION 1: Parent Authorization for Over the Counter (OTC) medication (e.g. Tylenol, Motrin, Benadryl, Antacid, Topical hydrocortisone or topical antibiotic) to be administered during the academic day and all school sponsored events**

OTC Medication Name_____

Dosage _____Frequency _____

**SECTION 2: Physician Authorization for prescription medication**

Please complete the following for any prescription medication to administered during the academic day and all school sponsored events.

The above name student is under my care for (diagnosis):_____

Medication(s) to be administered during school hours:_____

Dosage/Route/Frequency:_____

Date Begin:_____Date End:_____

Possible side effects:_____

Signature of Physician, CRNP or PA:_____Phone #_____

Printed name of Physician, CRNP or PA:_____Date_____

***PARENT SIGNATURE REQUIRED ON REVERSE SIDE***

An **Action Plan** is required for students with a history of asthma, diabetes, allergic reactions, seizures, or other chronic medical conditions requiring treatment.

**TO BE COMPLETED BY THE PARENT**

I request the medication listed above to be given to this student during school hours and all school-sponsored events. I understand that only I, or appointed school personnel, may administer this medication during school hours or school-sponsored events to this student. I acknowledge that the school shall incur no liability because of any conditions from the medication; I shall hold harmless the school, its employees, or agents against any claims arising from the administration of medication given to this student.

Signature of Parent:_____Date_____

**ALL MEDICATION WILL BE DISCARDED IF NOT PICKED UP BY THE LAST DAY OF THE CURRENT SCHOOL YEAR**