Policy 5330 F1 Revised 8/09

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MEDICATION REQUEST AND AUTHORIZATION

Complete one form for each prescribed medication. Guidelines on reverse side ⇨

Student: _____ School: _____ Grade/Room: _____ School Year: _____

Date of Birth: _____ Parent/Guardian: _____ Teacher: _____

Home Phone:_____ Work Phone: _____ Cell: _____

TO BE COMPLETED BY LICENSED PRESCRIBER ~

Name of Medication: _____ Strength_ _____

Reason for Medication: _____ Dose/Route:_____

Time(s) to be given at school: _____ Frequency: _____

For PRN Orders: Specific symptoms or conditions under which medication is to be given: _____

_____

Possible Adverse Reactions/Side Effects: _____

Actions to take if Observed: _____

For Insulin, PRN Asthma Inhalers or Epi-Pens only, complete if applicable:

☐ Yes ☐ No This child has received adequate instruction about how and when to administer this medication and in my professional opinion is capable and responsible to self-administer it.

☐ Yes ☐ No Due to the need for this child to have this medication immediately accessible, I recommend he/she be allowed to have this medication in his/her possession and to use it as prescribed.

Date of expiration: _____ Phone: _____ Fax:_____

Licensed Prescriber's Name/Address: _____
(Please Stamp or Print)

Licensed Prescriber's Signature:_____ Date: _____

I, the parent or legal guardian of the above named student, have read and understand the Medication Guidelines on the reverse side. I understand that medications are NOT given by licensed medical personnel but by designated trained school personnel. I give permission for designated school personnel to administer the above prescribed medication to my child or for my child to carry and self-administer this medication, if so authorized. I further give permission for designated school personnel to request and share relevant health information about my child and the administration of this medication with appropriate school personnel.

I agree to do the following:

- **Deliver or assume responsibility for safe delivery of this medication to school.**
- **Notify the school in writing if this prescription is discontinued.**
- **Submit a new written authorization form and labeled pharmacy container if this prescription changes in any way.**
- **Pick up any unused medication.**

Parent/Guardian Signature: _____ Date: _____

"Children are the highlights of our lives"