

# Medication Authorization Form

Policy Code:

JHCD-E

Adoption Date:

Tuesday, September 25th, 2012

Review Date:

Tuesday, October 28th, 2014

## MEDICATION AUTHORIZATION FORM

To: Principal of \_\_\_\_\_ School Date \_\_\_\_\_

RE: AUTHORIZATION FOR STUDENT MEDICATION RELEASE FORM

We the parents/guardians of \_\_\_\_\_ would like to request that medication be given to our child at school according to the directions specified below by our physician. We report that the medication in the container and the label have not been tampered with. We recognize that this is only a request and school officials may choose to honor or reject this request at their option. We release any and/or all school personnel from any liability that could be brought about by inadvertent failure to give our child the medication as indicated, or by any accidental overdose.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Parent/Guardian

The following medication is recommended to be given to \_\_\_\_\_ while he or she is at school or attending school activities.

- | Name of Medication                                                              | Dosage/Route | Time to be Given |
|---------------------------------------------------------------------------------|--------------|------------------|
| 1. _____                                                                        | _____        | _____            |
| 2. Side Effects: _____                                                          |              |                  |
| 3. Number of school days for which the need for medication is anticipated _____ |              |                  |

Please Circle:

Yes No Would this medication be dangerous if taken by any person other than the one for whom it was prescribed?

Yes No Does this medication require storage under refrigeration?

Yes No Would this medication prevent the child from participation in field trips or other school activities?

Yes No Is any of this medication specifically for seizure control?

Instructions in case of seizure \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Physician

Request Accepted \_\_\_\_\_ Denied \_\_\_\_\_ (If denied, please state reason on the reverse of this form.)

\_\_\_\_\_

Signature of School Principal

\_\_\_\_\_

Signature of School Nurse

\_\_\_\_\_

Signature of Assigned School Person