Health Network for Rural Schools
Authorization for Medication Administration
by School Personnel

To: _____ School District

Student: _____ **DOB:** _____ **Grade:** _____

Parent: _____ **Phone:** _____

Teacher: _____ _____

I am giving school personnel permission to assist in the administration of the following medication as directed below:

Parent/Physician to complete: ( ) Non-prescription

Medication: _____ ( ) Prescription Rx number _____

Dose (how much): _____ Description: _____

Frequency (how often): _____ _____

Route: Mouth Ear Eye Nose Skin

Time: _____

Medications must be from a legal pharmacy, in the original container, identified with the student's name and physician, and include instructions.

Duration: Start Date _____ End Date _____

Reason for Medication: _____

Please call parent prior to giving medication. _____ Yes _____ No

Special Instructions: _____
_____

Parent Responsibility - ensure medication is current, properly identified and available; notify the school in writing of any changes; *pick up all unused medication by the last day of school. All medications left beyond the last day of school will be discarded.*

School Responsibility - ensure medication is used as prescribed in this authorization.

This authorization applies only to the medication listed above and for the duration of treatment or school year. This also authorizes an exchange of information as necessary, between the school nurse, appropriate school personnel, and my child's health care provider.

Parent/Guardian Signature: _____ Date: _____

I have prescribed the above medication. Instructions on/in the box are accurate. Special instructions including adverse reaction and action required: _____
_____

Physician's Signature: (if adding comments) **_____ Date: _____**

MEDICATION ADMINISTRATION

Student: ___________________________________ **Medication:** _________________________________

Instructions / Precautions: ____

Date	Time	Notes	Staff		Date	Time	Notes	Staff