MEDICATION AUTHORIZATION FORM

(Please complete one form for each of your student's medications.)

Student's Name: _____ **DOB:** _____

Allergies: _____

Reason for medication or diagnosis: _____

Medication: _____

Dosage: _____ **Time of Day to be Administered:** _____ ☐ **AM** ☐ **PM**

School: _____ **School Year:** _____

In order for school personnel to administer any type of medication to the student, the Parent/Guardian must provide this signed authorization form. Medicine will be dispensed to the student by the School Nurse or by unlicensed school personnel trained and deemed competent by the School Nurse. The medicine must be sent to the school with complete instructions and in the original container with the Physician's Order **OR** pharmacy label firmly attached to the medication.

Please be sure to complete ALL of the information on this authorization form before returning it to school.

ANY OVER THE COUNTER MEDICATIONS MUST BE ACCOMPANIED BY A PHYSICIAN'S ORDER

Medication to be administered during the school day must be brought to the school by the Parent/Guardian. Parents/Guardians shall pick up unused medication within two (2) weeks of the last day of school or it shall be destroyed. This authorization is valid for one school year and must be renewed at the beginning of each new school year.

The first dose of any new medication should NOT be given at school.

****

PARENT/GUARDIAN STATEMENT

☐ *I, the undersigned Parent/Guardian of the student named above, request that a* ****trained staff member administer*** *the above medication to my student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Nurse immediately of any changes. I understand the Fayette County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or the medication will be destroyed.*

**** Parent / Student are responsible to have medication available at school.***

X _____ ____ / ____ / ____
(Parent/Guardian's Signature) Date

Home Phone: _____ Work: _____ Cell: _____

****

Reviewed by: _____ *RN Date:* _____