

## Medication Authorization Form

**When it is possible, medication should be administered at home, using a schedule that will not require doses during school hours.**

**Prescription medication** must be brought to school by the parent or guardian in the original pharmacy container with the original pharmacy label attached. The student's name, name of the medication, dosage, date and physicians name **MUST BE CLEARLY NOTED ON THE LABEL**. Any change in dosage or time of medication requires a new prescription from the physician. No exceptions.

**Over-the-counter medication** must be sent to the school by parent or guardian, in the original container, marked with the students' name. Only the instructions on the container will be followed, unless a physician provides alternative instructions, in writing.

The following procedures must be followed for medication to be dispensed at school:

- 1) The parent or guardian must provide all medications to be administered at school
- 2) A medication authorization form, signed by the parent or guardian, must be on file at school (one for each medication). This form will expire at the end of each school year.
- 3) The first dose of medication **MUST** be given by the parent or guardian.
- 4) All medication must be kept in the area designated by TES nursing staff. Students will be responsible for reporting to the Health Office at his/her specific time
- 5) It is required that medication that is a controlled substance (Ritalin, Adderall, ect) be brought in to the school by the parent or guardian in the original pharmacy container with instructions clearly printed on the label.\
- 6) If your child requires any exception to this general procedure, such as self-administration, see the school nurse.

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Time of Administration \_\_\_\_\_ Duration \_\_\_\_\_

Reason for Medication \_\_\_\_\_

Physicians Name \_\_\_\_\_

Permission/Release Statement to be completed by Parent or Guardian

I hereby give my permission for TES school personnel to dispense the above named prescription or over-the-counter medication to my child, named above. I certify that he/she has previously had at least one dose of the above medication and did not have an adverse reaction from it. I understand that any TES school employee who administers this medication to my child, in accordance with the written instructions from the medication label, shall not be liable for damages as a result of an adverse reaction suffered by the student because of administering such drug or because of mislabeled or altered product. For prescription medication, I hereby authorize the USD 464 school nurse to exchange information with the prescriber and with the pharmacy identification on the affixed pharmacy label.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Parent or Guardian

\_\_\_\_\_

Phone number