

SISTERS SCHOOL DISTRICT

**Authorization for Medication Administration by School Personnel**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_ School: \_\_\_\_\_

I am giving trained school personnel permission to administer medications to my child per the following (Parent or Physician please complete):

Medication: _____	<input type="checkbox"/> Non Prescription
Dose (how much): _____	<input type="checkbox"/> Prescription # _____
Frequency (how often): _____	
Route (check one): By: Mouth__ Ear__ Eye__ Nose__ Skin__	
Time: _____	
Duration: Start date: _____ End Date: _____	
Reason for Medication: _____	
_____	
Special Instructions: _____	
_____	

**ALL MEDICATION  
MUST BE IN ITS  
NEWEST ORIGINAL  
CONTAINER WITH  
ACCURATE LABELING**

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(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 personnel, and/or my child's health provider.

**\*PHYSICIAN DIRECTION\***

**(required in writing OR on pharmacy label for all prescription medications)**

I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate. Special instructions including adverse reactions and action require:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Name (Please print/stamp)                      Address                      Zip Code

\_\_\_\_\_  
Physician's Signature                      Phone                      Effective Date