

MEDICATION AUTHORIZATION

No medications (non-prescription/over the counter or prescription) will be administered by the school nurse, other school personnel or self (student) without the written authorization of a **physician and parent**.

Student's Name _____ Grade _____

Drug Allergies _____

Date of Birth _____ Height _____ Weight _____

Parent Complete	<p>I, _____ (do___) (do not___) authorize my child's health care provider and the school nurse to discuss my child's health concerns and/or exchange information pertaining to school health forms. <i>This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. I authorize the medication(s) checked below by the care provider to be given as ordered to my child.</i></p> <p>Signature of parent/legal guardian _____ Date _____</p>
Physician/Provider Complete	<p>The over the counter medication dosage will be administered according to the manufacturer's recommendations on the label unless otherwise indicated by a physician. Generic substitutions may be used for non-prescription medications listed. This form will also be the authorized form used for off campus activities, including overnight trips.</p> <p>Non-prescription medication stocked in office include the following (please check those that are to be given as needed):</p> <p> <input type="checkbox"/> Tylenol (Acetaminophen) <input type="checkbox"/> Motrin (Ibuprofen) <input type="checkbox"/> Benadryl <input type="checkbox"/> Cough drops <input type="checkbox"/> Tums <input type="checkbox"/> Neosporin/Hydrocortisone lotion/Benadryl spray and lotion/topical sting relief </p> <p>Please list any other medication which would need administering during school or school related activities, whether to be administered by school personnel or self (student).</p> <p>Name of medication _____ Dosage _____</p> <p>Route _____ Hours to be given _____</p> <p>Student may carry and self administer the medication ordered: yes _____ no _____</p> <p>Physician/Nurse Practitioner/PA</p> <p>Signature _____ Date _____</p>