

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

To: _____ of _____
(Principal) (School name)

Student Name: _____ DOB: _____ Grade: _____

Teacher: _____

I am giving school personnel permission to administer medications to my child per the following:

Parent/Physician to complete:	Parent please circle one of the following:
Medication: _____	Non-prescription
Dose (how much): _____	Prescription Rx Number: _____
Frequency (how often): _____	Please allow my child to self Administer this medication. (refer to district policy on Self Medication).
By: Mouth Ear Eye Nose Skin	
Time: _____	
Duration: Start Date: _____ End Date: _____	
Reason for medication:	
Special Instructions:	

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 as 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 school personnel, and/or my child's health care 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 required

Physicians Signature: _____ Date: _____
