School Medication Administration Authorization Form

This form must be completed fully in order for school staff to administer both prescription and over-the-counter medications to a student. A new form is required at the start of each school year and whenever there is a change in dosage or specialty instructions.

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1. Student Information

Student's Full Name:		Date of Birth:	MM/DD/YYYY
School Name:		Grade/Homeroom:	
Known Allergies:			

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2. Prescriber Authorization (To be completed by Licensed Prescriber)

Medication Name:		Strength/Dosage:	
Route of Administration:	e.g. Oral, Inhaler, EpiPen	Frequency / Time to Administer:	
Diagnosis/Reason for Medication:			
Possible Side Effects / Adverse Reactions:			
Special Instructions / Storage Requirements:			
Prescriber Name and Title:		Prescriber Phone Number:	
Prescriber Signature:	Sign here (Print to sign)	Date:	MM/DD/YYYY

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3. Parent/Guardian Authorization & Consent

I hereby request and authorize school personnel to administer the medication prescribed above to my child. I understand that the medication must be provided in its original pharmacy container, labeled with the child's name, medication name, dosage, and administration instructions.

Parent/Guardian Printed Name:		Primary Contact Phone Number:	
Emergency Contact Name:		Emergency Phone Number:	
Parent/Guardian Signature:	Sign here (Print to sign)	Date:	MM/DD/YYYY