Authorization to Dispense Medication

All medications must be brought directly to the nurse by the parent or guardian with this completed form.

NEVER send medication with the student.

MEDICATION MUST be in the ORIGINAL CONTAINER with the STUDENT'S NAME

Date _____

Student _____ Grade _____

Medication:_____ Dosage: _____Time_____Reason:_____ Exp:_____
Medication:_____ Dosage: _____Time_____Reason:_____ Exp:_____
Medication:_____ Dosage: _____Time_____Reason:_____ Exp :____
Medication:_____ Dosage: _____Time_____Reason:_____ Exp:_____

Parent or Guardian's Signature_____ **Phone #**_____

For Asthma or Diabetes:
I authorize my child to self-administer & carry his/her prescription asthma or diabetes medication while on school property or at school-related events. **YES** **NO**

Parent or Guardian's Signature_____ Phone # _____

A licensed health care provider must complete the following:

This student has asthma or diabetes and is capable of self-administering the prescription medicine.
YES **NO**
Name of medication _____ Dosage _____
Circumstances under which the medicine may be administered _____

Health Care Provider's Signature_____ **Phone #**_____ **Date** _____

For Narcotic/Controlled Substance Medications or Medication to be given daily for longer than 4 weeks:
A licensed health care provider **MUST** complete the following if a narcotic/controlled substance/long term daily medication is required to be administered at school.
Name of medication _____ Dosage _____
Circumstances under which the medicine may be administered _____

Licensed Health Care Provider's Signature _____
Phone # _____ **Date**_____

If a student requires a narcotic for pain, they should not be at school. An appropriate dose of pain control should cause drowsiness affecting the student's ability to learn. Special arrangements will be considered for long term health issues with appropriate documentation from a physician.

Updated 9/11/19

Please Document Medications Here

Student's Name_____Grade_____

Medication:_____
Medication:_____
Medication:_____

Date	Time	Medication	Dosage	Reason	Staff Initials	Parent Notified

Updated 9/11/19