Alabama State Department of Education

Form A
Revised 05/2003

# SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

## STUDENT INFORMATION

Student's Name _____

School _____ Grade _____ Teacher _____ School Year _____

List any known drug allergies/reactions _____ Height (inches) _____ Weight (lbs) _____

## PRESCRIBER AUTHORIZATION

Name of Medication _____ Reason for Taking _____

Dosage _____ Route _____ Frequency/Time(s) to Be Given _____

Begin Medication _____ Stop Medication _____
Date Date

**Special Instructions:**

Does medication require refrigeration? Yes ☐ No ☐

Is the medication a controlled substance? Yes ☐ No ☐

Is self-medication permitted and recommended for the student? Yes ☐ No ☐ **not allowed according to SCBOE medication policy except Inhalers and emergency medications**

If asthma inhaler or emergency medication, do you recommend this medication be kept **"on person"** by the student? Yes ☐ No ☐

**Potential Side Effects/Contraindications/Adverse Reactions** _____

**Treatment Order in the event of an adverse reaction:** (Attach additional sheet or use the back of this form if necessary)

_____ _____ _____ _____

**Signature of Prescriber** **Date** **Phone** **Fax**

## PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to delegate to unlicensed school personnel the task of assisting my child taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up about the medication. I authorize the prescriber or pharmacist to fax requested forms to the student's school.

Medication must be registered with the principal, his/her designee, or the school nurse. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate.

_____ _____ _____

**Signature of Parent/Guardian** **Date** **Phone**

I authorize and recommend self-medication by my child for the above medication. **(To be signed only if your child is on an inhaler or other emergency medication.)**

_____ _____

**Signature of Parent or Guardian** **Date**

If any questions or problems arise, call me at: (H) (W) (Cell)