

**Parent Authorization for Medication Administration**

**3416 F3**

Student name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian name (print): \_\_\_\_\_

Telephone number: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Emergency: \_\_\_\_\_

Other person(s) to be notified in case of a medication emergency:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality): \_\_\_\_\_

Any special directions, signs to observe, side effects:

My son/daughter has the following food or drug allergies:

Date to discontinue medication:

I am requesting the school personnel to administer the medication prescribed by:

Dr. \_\_\_\_\_

Medication must be presented in original packaging.

I am requesting that the school personnel administer this over-the-counter (OTC), \_\_\_\_\_ a non-prescription drug according to the manufacturer's directions.

The student has my permission to self-administer this medication.

I request the above student receive this medication according to the prescription or parental request for OTC drug, and any special instructions. I understand the information is confidential according to the Family Rights and Privacy Act (FERPA), and school personnel, needing to know, have access to this information. I agree to coordinate and work with school personnel and the prescriber if questions arise. I understand I may cancel this request at any time, and/or retrieve the medication from the school at any time. I understand the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/guardian signature: \_\_\_\_\_

Date:

Relationship to student:

