

# AUTHORIZATION FOR PRESCRIPTION MEDICATION AT SCHOOL (Med Form 2)

*Must be signed by parent.*

**Please print**

School year \_\_\_\_\_

Student's name \_\_\_\_\_

Date of birth \_\_\_\_\_

Parent \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Name of medication \_\_\_\_\_

Reason for dispensing medication at school (please be specific)  
\_\_\_\_\_  
\_\_\_\_\_

Amount of medication to be given \_\_\_\_\_

Date to **START** medication \_\_\_\_\_

Date to **STOP** medication \_\_\_\_\_

Time of day medication is to be given \_\_\_\_\_

Expiration date of medication \_\_\_\_\_

Possible side effects \_\_\_\_\_

Physician that prescribed this medication \_\_\_\_\_

Date \_\_\_\_\_

Physician's phone \_\_\_\_\_

## Parents, please read carefully:

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. ***I will notify the school if the medication is discontinued or the dosage has been changed.*** Permission is granted to the principal and/or school nurse to share this information with other school personnel who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the above named physician's office to request medical information concerning my child. I am responsible for replacing medication before the expiration date.

Parent's signature \_\_\_\_\_

Date \_\_\_\_\_

### Please note:

- A separate form is required for each medication to be given.
- Parents are responsible for noting the expiration date of all medication. Expired medication will not be given at school.
- Any medication not picked up by 2 weeks after the last day of school will be destroyed according to school guidelines.

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