BOB JONES ACADEMY

Authorization For Prescription Medication at School

Complete a separate authorization form for each medication.
Medication must be delivered to the school nurse by a responsible adult. Do not send medication with a student.
Whenever possible, medication should be given at home before or after school.
Prescription medications must be in the original pharmacy container with the current prescription label.
The information on this form must match the prescription label. Medications with mismatched information will not be accepted.
Herbal and alternative medical products will not be administered at school.
Medication cannot be administered until this form is complete and all required signatures have been provided.

Student's Legal Name:	Date of Birth:	Current Weight: _____lbs.	Allergies:
Name of Prescription Medication to be given at school:		**Purpose** of Medication at School:	
Prescribed Dose (Example: 5 mg, 10 mg, etc.)		**For Liquid Medication Only**: **Dose=**_____ ml	
Prescribed Time of Day for administration at school: (Example: 8 a.m., "after breakfast", or "lunchtime")	**Prescribed Route** (i.e., oral, inhaled, rectal, etc.)	**Special Instructions:** (i.e., crush, give with applesauce)	
Date to Start Medication:	**Date to Stop** Medication:		
List possible side effects:			
The physician that prescribed this medication:	Phone:		

Parents/Legal Guardians Please Read Carefully:
By signing below, I understand and agree to the following:

- I understand that all prescribed medications must be in the original container, clearly labeled with my child's name
- I will notify the school if the medication is discontinued or the dosage changes.
- I give permission to the school nurse(s) and/or designated staff to share this information with individuals who have responsibility for my child.
- I give the school nurse my permission to contact the prescribing Licensed Healthcare Provider and prescribing pharmacy in relation to this prescription medication.
- I am responsible for replacing medication before the expiration date.
- I give my permission for designated BJA staff to administer this medication to my child if needed.

Parent/Legal Guardian Signature:_____ Date:_____

Parent/Legal Guardian Printed Name:_____ Phone Number:_____

This form is only valid if signed on or after July 1st for the upcoming school year.

Revised 7/2026