Medication/Prescriber/Parent Authorization Form

Student Name________________________________Birthdate_________________Teacher______________________Grade________School Year_______________

To be completed by physician/licensed prescriber:

	Medication Name	Dose	Time To Be Given	Form/Route*	Side Effects	Adverse Reactions
1						
2						

*Routes – **oral** (pill/capsule/chewable,liquid) – **inhaled** (inhaler, nebulizer) – **topical skin application** – **topica**l (ointment, eye drops) – **Topical ear drop** – **Injection – Other** (list)

List minimal frequency between doses (especially if p.r.n.):____

**If p.r.n – list symptoms/conditions under which medication is to be given:_______________________________

Reason for medication: Medication #1_____________________________________Medication #2_______________________________

Special Instructions:____

Start Date (if not beginning of the school year)_________________________________ **Stop Date** (If not the end of the school year)____________________________

____ _____________ ____

Physician's Signature Date Physician's Printed Name

Physician's Phone #:______________________Fax #:____________________Address:______________________________________

To be completed by parent/guardian:

I request and give permission for (name of child)________________________________to receive the above medication(s)/treatment at school according to standard school district policy and for the physician('s)/staff and school district staff to share information needed to assist my child with medication needs. (Schools require parent/guardian to bring medication in its original container).

____ ___________________

Parent/Guardian Signature Date

IDA HIGH SCHOOL
MEDICATION POLICY

Dear Parents:

Please return the Medication Authorization Form (on the reverse side) to the school as soon as possible to enable us to aid you in administration of your child's medication.

We also ask that you follow these instructions when sending medication (prescription and/or over-the-counter) to the school. All medications must be brought to the office by a parent and dispensed by the office staff. Students are not allowed to have medications in their possession or take medications without the supervision of the office staff. The medication must be in it original container and be accompanied by written instructions from the student's physician and parent. The required form for providing this information is on the reverse side of this page. Other copies are available in the High School Office.

Parent Responsibilities -

1. All prescription, non prescription (over-the-counter), homeopathic medications shall be given only with a written order from the physician on the Building Medication Authorization Form (available in each building office), which shall include:
    - Name of student
    - Name of medication
    - Specific dosage
    - Route of administration
    - Time medication is to be given
    - Date of authorization and termination of administration.
2. Written Permission of parent or guardian must accompany the physician's order.
3. Any change in medication, dosage, or time will require a new authorization form to be completed.
4. All prescription medication must be administered only from containers properly labeled by a pharmacist.
5. All over-the-counter and homeopathic medication must be in its original packaging.
6. School personnel will not accept medication that is brought to the school wrapped in tissue, baggies, or plastic containers.
7. Medications shall be brought to school by the parent/guardian unless other safe arrangements are made and approved.
8. No medications shall remain in the building over the summer. Unused medication not picked up by the parent/guardian shall be disposed of.
9. The Building Medication Authorization Form shall be renewed every school year, unless otherwise noted on the "STOP DATE" portion of the form.
10. All controlled substances shall be counted together by the parent and staff, and recorded in the student medication record/log when received.