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Medication administration authorization– Non-prescription medications

Administration of over the counter medication requires both a licensed healthcare provider's order/ signature and parent written request on a Medication Authorization Form.

STUDENT _____

Grade/Class _____ Date of birth_____ School year 2024-25

Allergies (medication) _____

As the legal parent/guardian of the above-named student, I request the school to administer the medication below for the following conditions.

REASON FOR MEDICATION ADMINISTRATION: _____

MEDICATION NAME: _____ EXPIRATION: _____

Circle: SCHEDULED or PRN (as needed)

Dose: _____ Frequency _____

Administration time(s):_____

All medications must be FDA approved.

Parent Statement:

I understand that the school is not legally obligated to administer medication to my child. Therefore, I agree to defend and hold harmless, the school district and its employees from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements. Medication request must be deemed necessary to maintain or improve health and participation in the school program. Each request will be assessed for the most appropriate intervention and will be given at the standard dosage recommended by manufacturer.

- *I will notify the nurse if I give this medication to my child before arrival at school while this request is in effect to prevent overmedicating.*
- *I agree to supply medication for my student in its **original unopened packaging (small bottles only)**.*

Medical Provider name (printed):_____

Medical Provider Signature:_____

Medical Provider Phone number: _____ Date signed_____

Parent/Guardian Name (printed) _____Phone number: _____

Parent/Guardian signature:_____Date Signed: _____

Nurse's Signature: _____