Alabama State Department of Education

Form A
Revised 05/2003

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name ______________________________

School ______________ Grade ______ Teacher ______________ School Year ______

List any known drug allergies/reactions ______________ Height (inches) ______ Weight (lbs) ______

PRESCRIBER AUTHORIZATION

Name of Medication ______________________ Reason for Taking ______________

Dosage ______________ Route ______________ Frequency/Time(s) to Be Given ______________

Begin Medication ______________ Stop Medication ______________
Date Date

Special Instructions:

Does medication require refrigeration? Yes ☐ No ☐

Is the medication a controlled substance? Yes ☐ No ☐

Is self-medication permitted and recommended for the student? Yes ☐ No ☐ **not allowed according to SCBOE medication policy except Inhalers and emergency medications**

If asthma inhaler or emergency medication, do you recommend this medication be kept **"on person"** by the student? Yes ☐ No ☐

Potential Side Effects/Contraindications/Adverse Reactions ______________________________

____

Treatment Order in the event of an adverse reaction: (Attach additional sheet or use the back of this form if necessary)

____

____

Signature of Prescriber ______ **Date** ______ **Phone** ______ **Fax** ______

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to delegate to unlicensed school personnel the task of assisting my child taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up about the medication. I authorize the prescriber or pharmacist to fax requested forms to the student's school.

Medication must be registered with the principal, his/her designee, or the school nurse. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate.

Signature of Parent/Guardian ______ **Date** ______ **Phone** ______

I authorize and recommend self-medication by my child for the above medication. **(To be signed only if your child is on an inhaler or other emergency medication.)**

Signature of Parent or Guardian ______ **Date** ______

If any questions or problems arise, call me at: (H) (W) (Cell)