Banks School District

AUTHORIZATION FOR MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL (FORM A)

To: _____ of _____
Principal *School Name*

Student Name: _____ Date of Birth: _____

Teacher: _____ Grade: _____

I am giving school personnel permission to administer medication to my child per the following:

Parent or Medical Practitioner, please complete (one medication per form):

Name of Medication: _____

Dose (how much): _____

Frequency (how often): _____

Route (check one):

By: ☐ Mouth ☐ Ear ☐ Eye ☐ Nose ☐ Skin
Time: _____ AM _____ PM _____ Lunchtime

☐ Non-prescription

☐ Prescription

☐ Please allow my child to **self-administer** this medication. *(Parent must submit self-medication authorization form, form B.)* *Prescriptions require practitioner's written authorization, see below.

☐ Completed self-medication authorization form submitted, form B

Duration: Start date: _____ End date: _____

Reason for Medication: _____

Special Instructions: _____

☐ This medication must be taken along on field trips

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. *Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.*

Parent/Guardian Signature: _____ Date: _____

(This authorization applies only to the medication listed above and for the duration of treatment or school year.) This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.

MEDICAL PRACTIONER AUTHORIZATION

(Required in writing. Pharmacy label is acceptable in place of written physician order.)

I have prescribed the above medication for the student whose name appears at the top of this form. Instructions, as outlined above, are accurate.

☐ *Self-administration: Student is behaviorally and developmentally able to carry and self-administer above medication during school hours. REQUIRED for self-carry of prescription medications.

☐ Special instructions (including adverse reactions) and action required:

_____

_____

_____ _____
Physician's Name (Please print/stamp) *Address*

_____
City, State, Zip Code

_____
Physician's Signature *Phone Number* *Effective Date*