Cole R-1 School District

Parent Authorization for Medication Administration

Save Print

Student Name _____ DOB _____ Grade _____

Parent / Guardian Name _____

Cell Phone _____ Work Phone _____

Name of medication during school hours _____

For treatment of _____

Doseage _____

To be given (**check one**) ☐ as needed, every _____ hours

☐ at the following specific time(s) _____

Any special directions, signs to observe, side effects:

Check One:

☐ I am requesting the school nurse or designated school personnel to administer the medication **prescribed** by:

_____ to _____

(Licensed Prescriber) *(Student)*

☐ I am requesting that the school nurse or designated person administer this **over-the-counter (OTC)**, non-prescription drug according to the manufacturer's directions.

I give permission for exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regime.

I understand the information is confidential according to the Family Rights and Privacy Act (FERPA), and school personnel, needing to know, have access to this information. I agree to coordinate and work with school personnel and the prescriber if questions arise.

I understand I may cancel this request at any time, and/or retrieve the medication from the school at any time. I understand the medication will be destroyed if it is not picked up by myself or other designated adult within one week following termination or the order or by dismissal time on the last day of the school year.

Parent / Guardian Signature _____ Date _____

Relationship to Student _____