



Student Health & Medication Authorization Form

Complete all sections of this form and submit to the school office
if your child has an ongoing health issue and/or requires medication.

Medication Authorization (please print)

Student's name: _____

Birthdate: _____ M ___ F ___

Grade: _____ HR Teacher: _____

Condition requiring medicine: _____

Name of medicine: _____

Dosage: _____

Route (circle one): by mouth; in eye (Right, Left, both); in ear
(Right, Left, both); topical; other _____

Instructions: _____

Storage requirements: ___ none ___ refrigerate

Side effects: _____

Physician: _____

Physician phone: _____

Parent/Guardian: _____

Parent/Guardian phone: Home# _____

Work# _____ Cell# _____

Other# _____

Student Health Information

Does your child have ANY history of ... (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Physical Impairment |

Give details: _____

Does your child ... (check all that apply):

- Use an inhaler Frequency _____
- Use an EpiPen
- Take prescribed medication(s) routinely
- Require special seating in the classroom
- Have any condition that limits participation in P.E.

Give details: _____

To be completed by School Personnel:

Date received: _____ Name of Medication: _____ # doses received: _____

Medicine picked up FROM school by: _____

Parent /Guardian Please print

Parent /Guardian Signature

Date

Any other health conditions: _____

Check here if this medicine is ONLY for a field trip.

Name/location/date of field trip: _____

I authorize the principal or his/her designee to give medicine to my child according to the label directions. I authorize the principal or his/her designee to contact my child's physician if additional information regarding medication is needed.

Parent/Guardian Signature _____ Date _____

When possible, please give medicine doses at home before or after school. The first dose of a new medication should be given at home so parents can monitor for potential side effects or adverse reactions.

PLEASE NOTE

The principal or his/her designee will dispense medicine to students according to the following guidelines:

Medicine cannot be given without written permission and instructions from the parent/guardian. A new Medication Authorization must be completed whenever a new medicine or new dosage is to be given to the student.

The parent must bring medicine and related equipment to the principal or his/her designee. The student must not be in possession of medicine unless approved by the principal. All medication must be kept in the school office.

Prescription medicine, including inhalers, must be in the original labeled container. (Please ask your pharmacist for an extra label to be placed on the inhaler itself). Over-the-counter medicine must be in the original unopened container and marked with the student's name. Sample medications can only be given when accompanied by a note signed by the physician indicating sample medicine is for the student's use and medicine administration directions.

The parent should pick up unused medicine from the principal or his/her designee. Any medicine not picked up will be discarded at the end of each school year. Medicine will not be sent home with the student.

If the student is injured or becomes ill while at school, the principal or his/her designee will attempt to notify the parent/guardian and act according to their directions. If the parent cannot be reached, the principal will take the actions necessary to protect the health and well-being of the student.

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