Sevastopol Area School District
Medication Authorization Form

Student First & Last Name ______________________ Date of Birth ______________ Grade ________

*Note: Any change in medication will require a new form

Prescription Medication

I request the nurse or designated district staff to give this student his/her medication with the following recommendations and precautions such as amount to be given, frequency, and expected duration.

1. ____
   Name of Medication   Dosage   Instructions/Time   Reason
2. ____
   Name of Medication   Dosage   Instructions/Time   Reason

Current school year ________ yes ________ no   If no, dates: ____________ to ______________

Physician/Provider Name ______________ Physician/Provider Signature ______________ Date ______________

Parent/Guardian request/authorization for school district personnel to administer prescription medication at school:

I request the nurse or designated district staff to give my child his/her medication as written above.

Parent/Guardian Name ______________ Parent/Guardian Signature ______________ Date ______________

Non-Prescription Medication

I request the nurse or designated district staff to give this student his/her medication with the following recommendations and precautions such as amount to be given, frequency, and expected duration.

1. ____
   Name of Medication   Dosage   Instructions/Time   Reason
2. ____
   Name of Medication   Dosage   Instructions/Time   Reason

Medication shall be administered for current school year ________ yes ________ no If no, dates:__________ to __________

Parent/Guardian request/authorization for school district personnel to administer prescription medication at school:

I request the nurse or designated district staff to give my child his/her medication as written above.

Parent/Guardian Name ______________ Parent/Guardian Signature ______________ Date ______________

Request To Carry Medication

*** Grades 6-12 are allowed to carry (NO controlled medications)**

I request that my child be allowed to carry his/her medication (as written above) and be responsible for its proper storage and use. I will support my child to follow the below agreement & if s/he does not, I will be contacted to discuss an alternative plan. I understand the medication must be in the original packaging and kept in a secure location.

Parent/Guardian Signature: ________________________________Date: ______________

Physician/Provider Name ______________ Physician/Provider Signature ______________ Date ______________

I am able to demonstrate correct use/administration of my medication (as written above). I agree to not misuse my medication in any way. I am aware of the possible side effects that may occur while taking the above medication and agree that I will report to the office if any side effects may occur. I am aware that if I do not follow the above agreement my parent/guardian will be contacted to discuss alternative plan.

Student Signature ________________________________Date: ____________

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