

# The School District of Sevastopol

## Prescription Medication Authorization Form

Student's name: \_\_\_\_\_ Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time to administer \_\_\_\_\_

Reason medication is prescribed: \_\_\_\_\_

\_\_\_\_\_ I authorize the above medication be given as indicated to my son/  
daughter by his/her physician by school personnel as designated  
by the building principal.

\_\_\_\_\_ I authorize my son/daughter to possess and use a metered dose  
inhaler or dry inhaler for asthma while in school, at school  
sponsored events or while under supervision of a school authority.

- Parent/Guardian's signature \_\_\_\_\_

Date \_\_\_\_\_

- Signature acknowledges that I have talked with/trained school staff proper medication dispensing to my child.
- Principal Signature \_\_\_\_\_ date \_\_\_\_\_

- See back for dispensing dates, times and who administered.



**Administering Medication to Students Form**

Sevastopol School policy states that medication should be administered to schoolchildren by parents at home. Under exceptional circumstances, school personnel may dispense medication, but, before any medication is given, the following procedures must be followed.

1. Parents or legal guardians shall request and authorize in writing that the principal designate school personnel to administer medication to students.
2. All prescription medication shall be kept by school personnel in a locked cubicle or other safe place at school, unless otherwise authorized by the principal. The label on the container from the pharmacist shall contain the name and telephone number of the pharmacy, the student's identification, name of the physician, name of the drug, dosage, date, and when the medicine is to be given. Sections 5A and 5B of this form must be completed before prescription medication can be administered.
3. Prescription medication must be delivered to the appropriate principal's office by the parent/guardian or designated adult. Students are not to bring prescription medication to school.
4. Parents/guardians may request non-prescription medication to be administered by completing sections 5A and 5B of this form. Parents/guardians are cautioned that non-prescription medication administration should be requested on a limited basis.

**5. A. Parent completes:**

Student\_\_\_\_\_ Birthdate\_\_\_\_\_

Address\_\_\_\_\_ Phone\_\_\_\_\_

School\_\_\_\_\_ Grade\_\_\_\_\_ Teacher\_\_\_\_\_

I hereby request and authorize the principal or designee to dispense medication prescribed by the below named physician, to my child. I authorize school personnel to contact the physician directly regarding this medication and its effects. I was informed about the medication dispensing policy.

\_\_\_\_\_

**parent signature** **date**

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**5. B. Physician completes:**

Medication/specific instructions: \_\_\_\_\_

\_\_\_\_\_

Side effect requiring physician notification:\_\_\_\_\_

**Physician signature**\_\_\_\_\_ **Date**\_\_\_\_\_