AUTHORIZATION FOR DISPENSING MEDICATION

Name of Student: Sex: Date of Birth:

Name of Parent/Guardian: ______________________________

Address: ______________________________

To number (Home): ______________ Tel. number (Work): ______________

(Cell): ______________

Other Persons, if any, to be notified in case of emergency if parent/guardian is unavailable:

Name: ______________________ Telephone: ______________

Relationship: ______________________________

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality). Please list all medications the child is receiving, including those given during the school day:

My son/daughter is known to have the following allergies:

I give permission to have the school nurse administer the following medication(s) ______________
[Name of Medication(s)]

prescribed by ______________________ to ______________________
[Doctor or other Licensed Prescriber] [Name of Student]

I Give permission for my son/daughter to self administer medication if the school nurse determines it is safe and appropriate. Yes No

- I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if not picked up within one week following termination of the order or by the last day of the school year.

I understand that the school nurse may share with appropriate school personnel information relative to the prescribed — medication administration, e.g., adverse side effects, as she/he determines necessary for my son's/daughter's health safety. If you object, please contact the school nurse.

Signature of Parent/Legal Guardian ______________________________

Relationship to Student ______________________ Date ______________