Medication Authorization Form – Prescription Long Term (page 1 of 2)

STUDENT _____ **GRADE** _____

SCHOOL _____ **BIRTHDATE** _____

ALLERGIES (MEDICATIONS) _____

Student

Note: Prescription Medication must be in the original container indicating the following information: student name, dosage, healthcare provider, pharmacy, date issued, and prescription number.

PARENT STATEMENT: I request that the prescription medication listed below be given to my child named above.

- I understand that only current medications will be given at school.
- I understand that in the absence of the school nurse, other trained school staff may administer medication.
- I agree to defend and hold the school district employees harmless from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements.
- I give permission for the school nurse to contact the health care provider regarding this treatment.
- **I will notify the school immediately if the medication is changed and understand that the nurse may contact the health care provider or pharmacist regarding this medication.**
- ***I understand that this medication will be destroyed unless picked up by the end of the last student school day of this year per federal DEA requirements.***

Parent/Guardian Signature_____***Date***_____
Home phone _____ ***Work/Emergency Phone***_____
Other medications your child is taking_____

HEALTHCARE PROVIDER STATEMENT: This medication is required during school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication. The above named child should receive prescribed medication for the following condition: _____

- **Medication**_____
- **Prescribed daily dosage** _____
- **Time and dosage given at school**_____
- **Beginning date of medication**_____ **Ending Date**_____
- **Possible side effects**_____
- **Special instructions for administration**_____

Healthcare Provider Signature _____ ***Date*** _____
Printed Name _____***Phone***_____
Healthcare Provider Address_____
Healthcare Provider Email _____

School Nurse Signature_____***Date***_____
Phone _____ ***Fax*** _____***Email*** _____

Adapted from Anchorage School District form August 2012

Medication Authorization Form – Prescription Long Term

STUDENT _____ **GRADE** _____ **BIRTHDATE**_____

SCHOOL _____

Initial	Signature

Date, Amount of Med, Count Verified (initials)				
Month	**Week 1**	**Week 2**	**Week 3**	**Week 4**
Aug				
Sept				
Oct				
Nov				
Dec				

Date, Amount of Med, Count Verified (initials)				
Month	**Week 1**	**Week 2**	**Week 3**	**Week 4**
Jan				
Feb				
Mar				
Apr				
May				

Date, amt of incoming med	Date, amt of incoming med

MEDICATION_____ **DOSE** _____ **/ TIME** _____

Month_____ Month_____ Month_____ Month_____ Month_____ Month_____ Month_____ Month_____ Month_____ Month_____

Day	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**	**Day**	**Time/Init.**
1		1		1		1		1		1		1		1		1		1	
2		2		2		2		2		2		2		2		2		2	
3		3		3		3		3		3		3		3		3		3	
4		4		4		4		4		4		4		4		4		4	
5		5		5		5		5		5		5		5		5		5	
6		6		6		6		6		6		6		6		6		6	
7		7		7		7		7		7		7		7		7		7	
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29		29		29		29		29		29		29		29		29		29	
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31		31		31		31		31		31		31		31		31		31	