City Schools of Decatur

AUTHORIZATION OF MEDICATION ADMINISTRATION

(Prescriber's Order and Parental Permission)

Student_____**Date**_____

School_____**Date of Birth** _____

School Year_____**Allergies**_____

Name of Medication:_____**Dose**_____

Route (by mouth, topical, etc):_____ **Time(s) to be given:**_____

Medication shall be administered from:_____**to**_____

Month/Day/Year **Month/Day/Year**

Condition/Illness Requiring Medication: _____

All PRESCRIPTION MEDICATION WILL REQUIRE THE PRESCRIBING PROVIDER'S SIGNATURE BELOW.
Prescriber's signature on OTC medications is required **only** if dosage is not within the manufacturer's recommended guidelines or taken on a regular basis. All herbal and sample medications will require the prescriber's signature.

Special Instruction_____

Possible Side Effects, if any: _____

Action/Treatment for Side Effects_____

Prescriber's Name/Title:_____

Phone: _____ **Fax:**_____

Prescriber Signature:_____ **Date:** _____

I understand and agree:

- I hereby authorize the personnel, employees and officials of the City Schools of Decatur to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this medication.
- It will be the responsibility of the parent/guardian to inform the school of any changes. Changes in medication dosage, route or time of administration must be written and approved by legal prescriber and accompanied by signed medication authorization form by parent/ guardian.
- Completion of this form authorizes School Health staff to discuss all medications, orders or requests with the healthcare provider and the information may be shared with school personnel that need it to provide safe and appropriate care.
- All required medications must be in the original labeled container (over the counter and prescription). Pharmacists can provide a duplicate labeled container with only the school doses.
- I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the school listed above. My revocation will be effective upon receipt but will not be effective to the extent that the school or others have acted in reliance of this authorization.

Parent/ Legal Guardian signature: _____**Date:**_____

Parent/ Legal Guardian (Print Name):_____

Primary Emergency Phone_____ **Secondary Emergency Phone**_____

Medication pick up: Parent/Legal guardian signature: _____**Date:**_____

Revised 8/2020