Expires June 30, 20___

Medication Authorization Form

For Prescription and NonPrescription Medications

Student:____Date of Birth:_________________________________

Grade:____Homeroom Teacher:_________________________________

INSTRUCTIONS:

- Section A must be completed by the parent/guardian for ALL medication authorizations including cough drops and other over the counter remedies.
- Section A and Section B must be completed for any **PRESCRIPTION MEDICATION**, and also if the student will be **self-carrying and/or self-administering** (Middle and High School students only).

Section A: To be completed by parent/guardian

Medication authorization for: ____
(child's name)

Tri County Area Schools and its trained employees have my permission to administer the following medication:

Medication name:____

Dosage and times to be administered:____

Special instructions (if any):____

This authorization is effective until the end of the school year or until:_________________________________
whichever comes first. *(date)*

Parent's or Guardian's Signature:____Date:_______________

* Please note that while Tri County's Medication Administration policy allows for parents to request over that counter medication be administered to their child without having a physician's signature on file, we cannot exceed the allowed/recommended dosage, nor give it more often than recommended on packaging

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Section B: To be completed by child's physician

I,____certify that it is medically necessary for the medication(s)
(Name of Physician)
listed below to be administered to:___________________________________until the end of the school year
(child's name)
or until:__________________________whichever comes first.
(date)

Medication(s):____

Dosage and times to be administered:____

Special instructions (if any):____

Student may self-carry and self-administer this medication: YES NO
(Physician's signature is required if student is to self-administer. This option is available only for Middle and High School students who require an inhaler or Epi-Pen)

Physician's Signature:____Date:___________

Physician's Phone Number:__________________________Fax:________________________________

*I give permission for Tri County Area Schools to contact my child's physician if any questions or concerns should arise regarding this medication and/or the medical condition related to the use of this medication:____
(Parent's signature)

*All medication must be brought to the school by a parent/guardian and in its original package, clearly labeled with the student's name. Prescription medication must be in pharmacy container with appropriate labeling. Medication not in the original container cannot be accepted by school staff. Students are not allowed to transport medication of any kind by themselves with the exception of Middle and High School students who already have this completed form on file.

For Office Use Only (date the responses below)

Entered into Synergy______ Faxed for Physician Signature______ Medication Received _____