Moniteau County R-V

Parent Authorization for Medication Administration

Student Name ___________________________________ **DOB** _______________ **Grade** _________

Parent / Guardian Name ____

Cell Phone ______________________________________ Work Phone __________________________

Name of Medication during school hours ____

For treatment of ____

Dosage ____

To be given **(check one)**

- ❑ as needed, every ________ hours
- ❑ at the following specific time(s) __________________________

Any special direction, signs to observe, side effects:

Check one below:

- ❑ I am requesting the school nurse or designated school personnel to administer the medication prescribed by:

  __________________________________ to _______________________________
  (Licensed Prescriber) (Student)

- ❑ I am requesting that the school nurse or designated person administer this **over-the-counter (OTC)**, mom-prescription drug according to the manufacturer's directions.

I give permission for exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regime.

I understand the information is confidential according to the Family Rights and Privacy Act (FERPA), and school personnel, needing to know, have access to this information. I agree to coordinate and work with school personnel and the prescriber if questions arise.

I understand I may cancel this request at any time, and/or retrieve the medication from the school at any time. I understand the medication will be destroyed if it is not picked up my myself or other designated adult within one week following termination or the order or dismissal time on the last day of the school year.

Parent / Guardian Signature ______________________________________ Date ________________

Relationship to Student ____