

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____ - _____

STUDENT INFORMATION

Student's Name: _____ School: _____

Date of Birth: ____/____/____ Age: _____ Grade: _____ Teacher: _____

 No known drug allergies---if drug allergies list: _____ Weight: _____ pounds**OVER THE COUNTER PRESCRIBER AUTHORIZATION**

Medication Name: _____ Dosage: _____ Route: _____

Frequency/Time(s) to be given: _____ Start Date: ____/____/____ Stop Date: ____/____/____

PHYSICIAN ORDER REQUIRED by LEA: YES ___ NO ___ (all orders good for one calendar year less otherwise noted)

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:Is the medication a controlled substance? Yes No Is self- medication permitted and recommended? Yes No

If "yes" I hereby affirm this student has been instructed

On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student? Yes No

Printed Name of Licensed Healthcare Prescriber: _____ Phone: () _____ - _____ Fax: _____ - _____

Signature of Licensed Healthcare Prescriber: _____ Date: _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ Date: ____/____/____ Phone: () _____ - _____

SELF-ADMINISTRATION AUTHORIZATION**(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)**

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ Date: ____/____/____ Phone: () _____ - _____