TRIPOLI ELEMENTARY * 309 9TH Ave SW * 319 882 4203
TRIPOLI MSHS * 209 8TH Ave SW * 319 882 4202

PARENTAL AUTHORIZATION FOR MEDICATION ADMINISTRATION

Student Name:_____ Grade:_____

It is our policy that a parent or legal guardian must provide written authorization and instructions for school staff to administer medication to their student(s).

The following information is to be on the original prescription bottle and properly labeled by a registered pharmacist:

- Student Name
- Name of medication
- Dosage of medication
- Time to be given
- Ordering Physician's name

Medication	**Dosage**	**Route**	**Time to be given at school**	**Ordering Physician/Prescriber**

Special Instructions:

I request the above student and medication be given as prescribed by qualified staff. The information is confidential except as provided by the Family Educational Rights and Privacy Acts (FERPA) and any other applicable law. I agree to coordinate and work with school personnel and prescriber when questions arise. I agree to provide safe delivery of medication to and from school and to pick up remaining medication. Procedures for medication disposal shall be in accordance with federal and state law.

_____ _____ _____

Parent/Guardian Signature Phone Number Date

Please contact me via **TEXT** or **EMAIL** when medication is running low. (circle one)