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_____

Reason for taking medication:
Potential side effects/contraindications/adverse reactions:
Treatment order in the event of an adverse reaction:

ALL ORDERS ARE GOOD FOR ONE CALENDAR YEAR UNLESS OTHERWISE NOTED WITH "STOP DATE"

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 Provider:____________________**Phone:** ( )_______-_______**Fax:**_____-______

Signature of Licensed Healthcare Provider:____**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. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

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, OTCs 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:** ( )_______-_______