LOUISVILLE MUNICIPAL SCHOOL DISTRICT

School Medication Administration Authorization Form

This form must be completely filled out in order for specified personnel to administer the required/requested medication.

- *Prescription medications must be in a container labeled by the pharmacist or prescriber.*
- *Non-prescription medications **WILL NOT** be provided by office personnel and **CANNOT** be administered unless the following are provided:*
  - Parents must send proper documentation to school, indication specific instructions as to the administration of medicines.
  - Parents must send medication in the original container with the label intact.

Student's Name:_____
Last Name First Name

Grade_____ Homeroom Teacher: _____

List any chronic illnesses that your child may have (i.e. asthma, sickle cell, etc…).

_____

Please list any allergies that your child may have (including food, medication, insects, etc…).

_____

PARENT/ GUARDIAN AUTHORIZATION

I request that the medication provided to the school by me, the parent/guardian, be administered to the student named above. I certify that I have legal authority to consent to medical to medical treatment for the student named above, including the administration of medication at school. I understand that each individual school does not employ a school nurse; therefore, specified personnel will administer or observe my child taking the medication. I also understand the medicine will be administered only as stated on the medication label.

Name of Medication:_____

Parent/Guardian Signature: _____Date: _____

Home Phone: _____ Cell: _____ Work Phone: _____