Ada City Schools

School Health Services

ACS Health Services
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Authorization for Administering Prescription Medication

Every effort should be made to give medications at home. However, if your child must take a non-prescription medication at school, compliance with the following instructions is required.

Student's Name: _____ **DOB:** _____ **Grade:** _____

Parent/Guardian: _____ **Relationship:** _____

Phone: _____ **Work Phone:** _____

Emergency Contact - Name and Phone Number: _____

Physician's Name: _____ **Phone Number:** _____

This form must be completed by parent/guardian and the student's physician before a prescription medication will be administered.

A new form must be completed for each change in medication and renewed each school year. The pharmacy should prepare a bottle for school with the following information: Child's Name, Medication, Dosage, Frequency, Directions for Administering, Doctor's Name, and Date Filled. Medication not sent in original bottle or container and properly labeled will ***NOT*** *be given.*

To Be Completed By Parent/Guardian:

I, the undersigned parent/guardian, request that a designated school employee administer to my child the following medication. I also understand the school nurse may contaact the physician as needed and medication information will be shared with school personnel who have a need to know.

Name of Medication and Dosage: _____

Times To Administer: _____

_____ _____

Date **Parent/Guardian Signature**

To Be Completed By Physicians:

The above named student is currently under my medical care, and has a medical condition that requires him/her to take prescription medication daily during school hours.

Reason/Purpose: _____

Name of Medication and Dosage: _____

Directions for Administering, Including Time: _____

_____

If medication is to be given "as needed", describe indications: _____

_____

List significant side effects: _____

Length of time medication is to be given: _____

_____ _____

Date **Physician's Name**

_____ _____

Physician's Phone **Physician's Signature**

A photo copy or fax copy of this form is valid.