Student Medication Authorization Form

Today's Date: _____ Child's Teacher: _____

My child, _____ has been prescribed medication and/or has permission to take non-prescription medication during school hours.

He/She will take:

Medication: _____

Strength (in mg): _____ **Dosage** (amount to be given): _____

- ☐ **Daily** (time): _____ Mon – Fri (valid for 9 months/School Year)
- ☐ **As needed** (reason): _____ (valid for 9 months/School Year)
- ☐ **Other: _____ (**valid for 10 school days max)

I hereby authorize the following personnel to administer this medication to my child.

_____ School Nurse _____ School Staff (office/teacher)

All **prescription** medication that needs to be administered during school hours must be in its **original labeled container as dispensed by the pharmacist** or it **cannot** be administered at school.

All **non-prescription** (over the counter) medication must be brought in a **new and unopened** container or it **cannot** be administered at school. We will call before giving any "as-needed" medication. If your child **is under the age of 2** then a physician's medication order will also be required for any over-the-counter and prescription medication to be given at school.

I release the school, school board members, officers, and personnel and will hold Parkview Baptist School and such persons harmless from any damages, liability, or loss resulting from compliance or attempted compliance in good faith with this request and authorization. I recognize that I am primarily responsible for administering medications to my child and realize that Parkview Baptist School is not assuming responsibility for my child's care but is acting on my behalf when I am unable to personally administer a medication.

Signature of Parent/Guardian: _____Contact Number: _____

Parent Contacted (Name)	Date Given	Time Given	Dosage	Route	Observation completed by	Staff Signature