

Administrative Procedure 325 – Appendix A**PRESCRIBED MEDICATION FORM**

Student: _____ Grade: _____

Date of Birth: _____ School: _____

Name of Family/Agency: _____

Home Address: _____

Telephone: (Home) _____ (Work) _____

REQUEST AND AUTHORIZATION:

I hereby authorize and request the administration of the following prescribed medication for my child, _____, by non-medically trained staff at _____ School.

Date: _____ Signature: _____

Name of Student's Doctor: _____ Telephone: _____

Name of Student's Pharmacist: _____ Telephone: _____

Medication Prescribed**Dosage****Side Effects**

1. _____

2. _____

Other Pertinent Information (time of day, 2 weeks, etc.):

Annual Validation

This authorization is valid from _____ to _____
(maximum of 12 months)

NOTE: Parents may be requested to provide pertinent written medical data to be obtained from the pharmacist before the administration of medication can occur. (e.g. information sheets on specific medication)

I hereby acknowledge receipt of a copy of this form.

Signature of Student's Physician/Pharmacist: _____

Date: _____

NOTE:

1. Families/agencies are required to contact the principal of the school if there is a change in medication and/or dosage.
2. It is expected that only small quantities of medication will be sent to school.
3. After initial completion of the form, annual validation (signature) from the student's physician or pharmacist is not required for Epipens.