



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 _____ Allergies (please list) _____

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ Dosage: _____ Route: _____

Frequency/Time(s) to be given: _____ Start Date: _____ Stop Date: _____

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of adverse reaction: _____

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 the proper self-administration of the prescribed medication.

Do you recommend this medication be kept "on person" by student? ☐ Yes ☐ No

Cake Icing Gel ONLY FOR Diabetic Student during Bus Transportation? ☐ 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.

Prescription Medication must be registered with the School Nurse or Trained Medication Assistant. 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 presented to the School Nurse or Trained Medication Assistant. OTCs must be in the original, unopened, and sealed container. **OTC medication may not be kept for more than 2 weeks without written authorization from an authorized licensed healthcare provider.** Local Education Agency Policy for OTC medication must be followed.

Parent's/Guardian's Signature: _____ Date: _____ Phone: _____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed **ONLY** if student is authorized for 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 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).

Parent's/Guardian's Signature: _____ Date: _____ Phone: _____



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School Year _____ - _____

STUDENT INFORMATION

Student's Name: _____ School: _____

Date of Birth: _____ Age: _____ Grade: _____ Teacher: _____

_____ No known drug allergies _____ Allergies (please list) _____

Over-The-Counter Medication Authorization

Medication Name: _____ Dosage: _____ Route: _____

Frequency/Time(s) to be given: _____ Start Date: _____ Stop Date: _____

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of adverse reaction: _____

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.

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