**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: _____**