PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION OF MEDICATION TO STUDENTS

_____ ___/___/___ ____/___/___

Student's Name (Last), (First), (Middle) Birthday Today's Date

School medications are administered following these guidelines:

• *ALL NON-PRESCRIPTION MEDICATION MUST BE IN THE ORIGINAL MANUFACTURERS PACKAGE.* The package must include the name of the medication, strength, and directions for administering.

• *ALL PRESCRIPTION MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION CONTAINER AS DISPENSED BY THE PHARMACY.* The label must include the student's name, name of the medication, directions for use, prescribing provider and date.

• Parent / Guardian has provided a signed, dated authorization to administer medication. Completed electronic medication authorization acceptable in place of this form.

• Authorization is renewed annually and as soon as practical when the parent notifies the school that changes are necessary.

Medication Name _____

Medication Dose _____

Reason For Medication _____

Time to be Given or As Needed _____

Number of Days to be given Days to be Given or Daily _____

☐ I will only provide medication that meets the Highland CSD Medication Administration policy as outlined above.

By signing your name below, you are authorizing a HCSD staff member to administer this medication according to district policy.

Parent / Guardian Signature_____

Parent / Guardian Printed Name_____