Code: JLCD-E

AOS 91 Medication Authorization Form

MDIRSS AOS # 91

STUDENT _____ **BIRTHDATE** _____

SCHOOL _____ GRADE_____

ALLERGIES_____

PARENT STATEMENT:

- I request that the medication listed below be given to my child named above.
- I understand that medication must not be expired.
- I understand that in the absence of the school nurse, other trained school staff may administer medication.
- I understand that the school nurse may contact the health care provider or pharmacist regarding this treatment.
- I will notify the school immediately if the medication is changed.
- I understand that this medication will be destroyed per federal DEA requirements unless picked up by the end of the last student school day of this year.

Parent/guardian signature_____ Date_____

Home/cell phone _____ Other Emergency phone_____

Other medications your child is taking_____

_____

HEALTHCARE PROVIDER STATEMENT: This medication is required during school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication. The above-named child should receive prescribed medication for the following condition: _____

Medication name_____ Prescribed dose/Route_____

Dose at school _____ Time to be given at school_____

Beginning date of medication_____ Ending date_____

Possible side effects_____

Special instructions_____

Healthcare provider signature _____ Date _____

Printed name _____Phone_____

Healthcare provider address_____Healthcare provider email _____

School nurse signature_____Date_____

Phone _____ Fax _____

Approved: 01/23/17 Revised: 11/14/22