MEDICATION AUTHORIZATION FORM FOR MEDICATIONS WITHOUT STANDING ORDERS

STUDENT NAME _____ GRADE_____

SCHOOL _____ BIRTHDATE _____

ALLERGIES _____

Note: Prescription medication must be in the original container indicating the following information: student name, medication, dose, route, time to be administered, and healthcare provider. Over-the-counter medications must be in the original container with clear labeling.

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 Phone _____ 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:_____ Dose at School:_____

Time Given at School: _____ Beginning Date of Medication: _____

Route: _____ Ending Date: _____

Special Instructions _____

Possible Side Effects _____

Healthcare Provider Signature _____Date_____

Printed Name_____Address _____

Phone _____ Fax _____ Email _____

School Nurse Signature_____

Please return this form to the office for the School Nurse to review

ADOPTED: DECEMBER 3, 2025
TO REPLACE POLICY JLCD E-3, REVISED OCTOBER 20, 2005