PULASKI COMMUNITY
SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION ADMINISTERED AT SCHOOL

IDENTIFICATION	STUDENT: ____________ DATE OF BIRTH: ________ DATE: ______ SCHOOL/TEACHER:: ____________ SCHOOL YEAR: ________ PARENT/GUARDIAN: ____________ ADDRESS: ____________ PHONE: ________

SCHEDULED MEDICATIONS

Name of "scheduled" medication: ____________
Condition for which medication is being administered: ____________
Dose: ____________ Route: ________ Time of administration: ____________
Specific side effects to be monitored at school:

- ☐ None
- ☐ ____________

Medication shall be administered from: ____________ to ____________
Month/Day/Year Month/Day/Year
Other considerations:: ____________

AS NEEDED MEDICATIONS

Name of "as needed" medication: ____________
Administer medication for the following symptoms: ____________
Dose: ____________ Route: ____________
Can this medication be repeated?

- ☐ No
- ☐ Yes, every ________ hours

Specific side effects to be monitored at school:

- ☐ None
- ☐ ____________

Medication shall be administered from: ____________ to ____________
Month/Day/Year Month/Day/Year
Other considerations: ____________

PARENT/GUARDIAN AUTHORIZATION

I hereby give permission for school personnel to administer the above medication(s) to my child. I am aware of the following:

- ☑ Prescription medication must be in original pharmacy bottle/container.
- ☑ Over the counter medication must be in the original container with the label intact. A physician's signature is required for dosage other than what is stated on the label.
- ☑ An adult must bring the medication to school.
- ☑ The school nurse is authorized to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- ☑ Each medication requires its own paperwork and any changes in medication dose or regimen require new paperwork.
- ☑ Medication left at school after the last day of the regular school year will be destroyed.

Parent signature: ____________ *date* ________

PHYSICIAN AUTHORIZATION

Physician name: ____________ phone: ________
Address ____________ fax: ________
Physician signature: ____________ date: ________

*All prescription medications and over the counter medications that exceed the recommended dose on the label, require a physician authorization signature.