ROWANTY TECHNICAL CENTER

Authorization for Medication Administration at School

With the exception of acetaminophen, ibuprofen, and naproxen, all medication administered at school shall require the completion of this authorization form by parent/guardian and licensed prescriber.

(A separate parent authorization form is required for the aforementioned medications.)

PARENT/GUARDIAN SECTION

Student _____ DOB_____ Medication Allergies _____

I, _____, parent or legal guardian of above student, request that the principal's designee at Rowanty Technical Center administer the below prescribed medication to my child. I give the principal's designee permission to contact the licensed prescriber if necessary. In signing this form, I am agreeing to hold the school and its personnel free from any legal action that might arise from this arrangement.

I also understand that I am to abide by the school division regulations as stated below:
- It is my child's responsibility to come to the main office to take his/her medication.
- Parent or guardian must bring medication into school office. Medication cannot be transported on buses or by students.
- The first dose of a new medication should be given at home.
- Prescription medication must have a current prescription label that corresponds with the written authorization below.
- Over-the-counter medication must be in the original, unopened container, labeled with student's name.
- Any changes in a medication require a new written authorization and corresponding change in the prescription label.
- Parent or guardian must provide medications/equipment required to administer medications or provide special medical care.
- Left over medication must be picked up at the end of the school year or it will be discarded.

Parent/Guardian Signature _____ Date _____

Parent/Guardian PRINTED Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

LICENSED PRESCRIBER SECTION

(Must be completed by Physician / Dentist / Nurse Practitioner / Physician Assistant)

I certify that, in my opinion, it is medically necessary that the medication prescribed below be administered to _____ (Name of Student) during school hours and that this medication may be administered by school personnel.

Prescription: Medication: _____

Dosage, Time and Route: _____

Duration: _____ Date of Prescription: _____

Diagnosis Requiring Medication: _____

Possible Side Effects: _____

Special Handling Instructions: _____

Prescriber Signature_____ Date _____

Prescriber PRINTED Name _____

Prescriber Phone _____ Fax _____

Prescriber Address _____