Parent/Guardian Authorization to Administer Medication at School

The parent/guardian of _____ **Grade:** _____ **requests that the staff at**
(Child's Name)
_____ **administer the following medication to my child, according to the Health Care Provider's**
(School Child Attends)
signed instructions on the lower part of this form:

Medication:_____ **Dosage/Amount:**_____ **Time(s):**_____

Prescription medication must come in a container labeled with the child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.
Over the counter medication must be labeled with the child's name. Dosage must match the signed health care provider authorization below and medicine must be packaged in the original container.

- Littleton Public Schools agrees to administer medication prescribed by a licensed health care provider.
- For safety reasons, parents are requested to bring the medication directly to the school office.
- Unused medication that is not picked up by the parent will be discarded one week after the end of the school year.
- New medication authorization forms must be completed each time there are any changes in medication or dosage, **and** at the beginning of each school year.

It is understood that medication is administered solely at the request of, and as an accommodation to, the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by any personnel employed by Littleton Public Schools, the undersigned parent or guardian hereby agrees to release the said institution and their personnel from any legal claim(s) which they now have, or may hereafter have, arising out of the administration of (or failure to administer) the medication to the student.
By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the school nurse or school staff delegated to administer medication.

_____ _____ _____
Parent/Guardian's Name (Print) Parent/Guardian's Signature Date

_____ _____
Work Phone Home Phone

Health Care Provider Authorization to Administer Medication at School

Child's Name:_____ **Birth date:** _____

Medication: _____

Dosage/Amount: _____ **Route** _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

Starting Date: _____ **Ending Date:** _____ **Storage Requirements:**_____

_____ _____
Signature of Health Care Provider with Prescriptive Authority **License Number**

_____ _____ _____
Print name of Health Care Provider **Phone Number** **Date**

Please ask the pharmacist for a separate labeled medication bottle to keep at the school

For Office Use Only: (Initial & date)
_____ Parent authorization signed _____ Health Provider authorization signed _____Med label & dosage matches all written authorizations
_____ Medication log completed _____Staff initials/Signature _____RN signature and date 5/08