AUTHORIZATION FOR MEDICATION ADMINISTRATION
by Jefferson School District Personnel

Student Name ______________________________ DOB _____________ Grade __________

Classroom/Homeroom Teacher ____

I am giving school personnel permission to administer medication to my child per the following:

This Section Completed by Parent/Guardian	
Please allow my child to self-administer this medication. (JSD Policy JHCD/JHCD-AR)	
Medication:______________________________	❑ Non-Prescription
Dose (how much):_________________________	Prescription Number: ______________________
Frequency (how often): ____________________	Medication Expiration Date: _________________
Route (circle) By: Mouth Ear Eye Nose Skin	Special Instructions: ______________________
Time: ______________________________	____
Duration: Start Date __________________	____
End Date ___________________	____
Reason for Medication: ____	

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. I also understand parents/guardians are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

Parent/Guardian Signature: ___________________________________ Date: ________________

This authorization applies **only** to the medication listed above and for the duration of treatment or school year. This also authorizes an exchange of information as necessary between appropriate school personnel and/or my child's health care provider.

Permission of the building principal is required for all self-medication requests as per policy JHCD-AR.

_______________________________________ ________________________

Principal's Signature Date

- medication sign in/sign out on back -

Medication Sign In

Medication	Dose	Date Received	Amount Received	Parent/Guardian Signature	School Personnel Signature

Medication Sign Out

Medication	Date	Activity/Event	Signed Out Signature	Signed In Signature