Madison School District

Nurse Ellen Young

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Madison School District Medication Authorization Form

Name of Student: _____ Date of Birth: _____

Name of Drug	1)	2)	3)	Tylenol/Motrin *(circle one if necessary)*
Amount of medication				
Time of Administration				
Route of Administration				
Possible Side Effects				
Special Concerns or Comments				
Student capable of self-administering medication	YES NO *(circle one)*	YES NO *(circle one)*	YES NO *(circle one)*	YES NO *(circle one)*
Student may carry medication on person	YES NO *(circle one)*	YES NO *(circle one)*	YES NO *(circle one)*	YES NO *(circle one)*

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

1) No medication will be given without an order signed by the physician.
2) All prescription bottles must be labeled by the pharmacy with a current date, the name of the student, name of the medication, strength of the medication, and the time given.
3) All non-prescription medication must come to school in its original packaging.
4) Any change in dosage or addition of new medication must be accompanied by written physician statement.

I hereby request that my student be administered his/her medication by the school personnel authorized by the principal/supervisor. I understand that medication will be administered as per the instructions of my above named physician. I will notify the school of changes or discontinuation of this medication(s).

Parent/Guardian Signature: _____ Date: _____

I request (name of student) _____ be allowed to self-administer and carry the above medication at school according to school policy.

Parent/Guardian Signature: _____ Date: _____