AUTHORIZATION FOR PRESCRIPTION MEDICATION AT SCHOOL

- PLEASE COMPLETE A SEPARATE FORM FOR EACH MEDICATION
- Medication must be brought to the front lobby by a responsible adult. (do not send medication with a peer.)
- Medication should routinely be given at home before or after school, whenever possible.
- All prescribed medication must be in the original container issued by the pharmacist with the most recent prescription label.
- If the information on the authorization form does not match the prescription label, the medication will not be accepted.
- Herbal/alternative medical products and narcotic medications will not be administered in the school setting.
- Medications will not be administered without this completed form including required signatures.

THIS SECTION MUST BE FILLED OUT BY A LICENSED HEALTH CARE PROVIDER ONLY- PLEASE PRINT

Peer's Legal Name:	Date of Birth:
List Allergies:	Name of Medication:
Purpose of Medication:	Time of day for administration at school :
Prescribed Route:	Date to Start Medication: Date to Stop Medication:
Possible Side Effects:	Licensed Health Care Priver Name:
Licensed Health Care Provider Address:	Phone: Fax:
Licensed Health Care Provider Signature:	Date:

PARENTS/ LEGAL GUARDIANS PLEASE READ CAREFULLY:
BY signing below, I understand and agree to the following:

- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication is discontinued or the dosage has been changed.
- I give my permission to administration to share this information with individuals who have responsibility for my Peer.
- The first dose of any new medication will be given at home so that I can monitor for adverse reactions.
- I give NHS Schools permission to contact the above named Licensed Health Care Provider and prescribing pharmacy in relation to this prescription medication.
- I am responsible for replacing medication before the expiration date.
- I give my permission for designated NHS School staff to administer this medication to my Peer.

Parent/Legal Guardian's Signature ______________________________________ Date: _____________________

Parent/ Legal Guardian Printed Name: ________________________________ Phone Number: _________________