PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION TO STUDENTS

_____	___/___/___	_____	___/___/___
Student's Name (Last), (First), (Middle)	Birthday	School	Date

School medications and health services are administered following these guidelines:

- Parent has provided a signed, dated authorization to administer medication and/or provide the health service.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student's name, name of the medication, directions for use, and date.
- Authorization is renewed annually and immediately when the parent notifies the school that changes are necessary.

_____	_____	_____	_____
Medication/Health Care	Dosage	Route	Time at School

_____

_____
Administration instructions

_____

_____
Special Directives, Signs to Observe and Side Effects

_____/_____/_____
Discontinue/Re-Evaluate/Follow-up Date

_____
Prescriber's Name and Clinic Location

I request the above named student take medication at school/school activities, according to the prescription, instructions, and a written record kept. Special considerations are noted above. The information is confidential except as provided to the Family Education Rights and Privacy Act (FERPA). I agree to coordinate and work with school personnel and prescriber when questions arise. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

_____	_____/_____/_____
Parent's Signature	Date
_____	_____
Parent's Address	Home Phone

Cherokee Community School District