Rockford Public Schools
Quality Community – Quality Schools
Together Building a Tradition of Excellence

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Medication Authorization Form

Student: _____ Date of Birth: _____

School: _____ Teacher/Advisor: _____

Grade: _____ Date form received by the school: _____

Medication Policy Reminders:

1. No medications will be administered to a student without written permission from parent or guardian AND physician recommendations. A permission form must be signed and on file for each child who receives a medication at school.
2. New authorization is needed at the beginning of each school year and for each medication.
3. **All medications must be brought to school by parent or guardian.**
4. All medications must be in the original container and appropriately labeled. **School personnel will not administer unlabeled medications.**
5. No medications are to be kept with the student except those required for asthma or allergic reaction. Specific authorization forms must be filled out for Inhalers and EPI pens. See second page.
6. The parent or guardian must pick up unused medications. No medications will be stored over the summer. Remaining medications or contaminated medication will be disposed of properly at the conclusion of the school year.

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of medication: _____

Reason for medication: _____

Form of medication/treatment:

☐ Oral tablet/capsule ☐ Liquid Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Dose: _____ Time to be given at school: ☐ PRN ☐ lunch Other: _____

If PRN, list symptoms/conditions under which medication is to be given: _____

_____

Special Instructions: _____

Restrictions and/or important side effects: ☐ None anticipated ☐ Yes, Please describe:

_____

Special storage requirements: ☐ None ☐ Refrigerate

Start: ☐ Date form received Other dates: _____
Stop: ☐ End of school year Other date/duration: _____

Physician's stamp

Physician's Name: _____

Address: _____

Phone Number: _____ Fax: _____

Physician's Signature: _____ **Date:** _____

To be completed by parent/guardian

I request that the above named student receive the above medication at school according to standard school policy and for the physician/provider staff and school staff to share information needed to assist my child with his/her health and medication needs. I assume responsibility for safe delivery of the medication to school. I will notify the school immediately if there is any change in the use of the medication or treatment. I release and agree to hold the Board of Education and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____ _____

Parent/Guardian Signature **Printed name** **Date**