Cashion Public Schools

PRESCRIPTION MEDICATION AUTHORIZATION FORM

Every effort should be made to give medicines at home as giving it at school can cause a disruption in the student's school day. If, however, your physician does order medicine to be taken during the regular school day, compliance with the following instructions is required:

Student Name_____Grade_____

DOB_____Address_____

Parent # 1 Name_____Parent # 2 Name_____

Home Phone_____Cell Phone_____
Work Phone_____

Physician's Name _____Phone Number_____

TO BE COMPLETED BY THE PARENT/GUARDIAN This form must be completed by a parent or guardian before a prescription medication can be administered by a designated school employee. A new form must be completed for each change in medication and renewed each school year. It is recommended to have your pharmacist prepare an additional bottle for school use properly labeled with the child's name, medication, dosage, time, doctor's name, prescription number, name and address of the pharmacy and date of filling. Any medication not properly labeled will not be given. ***Prescription label must match the physician instructions on back before the medication can be given at school. **Medications are not to be shared while at school. ****According to policy, parent/guardian must transport medications to school. Do not send medications with your child. I, the undersigned parent/guardian, have read and understand the instructions listed above and request that a designated school employee administer to my child the following medication. *

Medication Name _____Dosage _____

Time given: □ 8:00am □ 9:00am □ 10:00am □ 11:00am □ 12:00pm □ 1:00pm □ 2:00pm □ 3:00pm □ As needed for Epinephrine pen □ As needed for Glucagon □ As needed for Diastat □ As needed every _____ hours Length of time to be given: □ Entire school year □ Specific time period _____ Parent Name (please print) _____

Date _____ Parent Signature _____

*The physician instructions (on back) must match your instructions above.

TO BE COMPLETED BY THE PHYSICIAN

Student's Name_____

Diagnosis for which Medication is given: _____

Medication Name: _____

Dosage: _____

Time of Administration: (Must indicate specific time)

- ☐ 8:00am ☐ 9:00am ☐ 10:00am
- ☐ As needed for Epinephrine Pen

☐ 11:00am ☐ 12:00pm ☐ 1:00pm ☐ 2:00pm ☐ 3:00pm ☐ As needed for Glucagon ☐ As needed for Diastat

*** Medication is given 30 minutes before or 30 minutes after ordered time.

*** Prescription label MUST match Medication name, dosage and time ordered above. A separate Prescription for school bottle use is suggested for pharmacy.

Relevant side effects: ☐ None expected ☐ Specify: _____

_____

Length of time to be given: ☐ School year ☐ Specific time period _____

Other information: _____

_____

_____

***** Required *****

Physician Signature: _____

Physician Name/Title: _____ (Please print or type)

Date: _____

Telephone: _____ Fax: _____

Address: _____