HOUGHTON MIDDLE SCHOOL

Medication Parent Authorization Form

Student Name: ______________________________ Birth Date: ____________

Grade: _________ Homeroom: _________ School Year: __________

Medication Name	Dose	Time(s) to be given	*Route	Adverse Effect/Reactions

***Routes**: Oral (pill/capsule/chewable/liquid), Inhaled (inhaler/nebulizer), Topical Skin Application, Topical Eye Ointment, Topical Ear Drop, Injection, and Other.

List minimal frequency between doses (especially if p.r.n.): ______________________

If p.r.n., list symptoms/conditions under which medication is to be given: ___________
____

Special Instructions: ____

____

Physicians Printed Name & Signature

Physicians Phone # __________________ Fax # __________________

<u>To be completed by parent/guardian:</u>

I request and give permission for __________________________ to receive the above medication(s) and/or treatment at school according to standard school district policy and for the physician(s)/staff and school district staff to share information needed to assist my child with medication needs. It is our school's policy to have a permission slip signed and on file for the prescription medications being administered to your child. Medications must be in the original container; labeled with date/expiration date; prescription; student name; and exact dosage to be administered. Medications should be brought to school by a parent or guardian unless other safe arrangements have been made. A parent and/or guardian must pick up all medications left at the end of the school year. All medications will be disposed of two weeks after the end of the current school year if not picked-up.

Parent/Guardian Signature: ___________________________ Date: ___________