



# Cole R-1 School District Parent Authorization for Medication Administration

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Parent / Guardian Name \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of medication during school hours \_\_\_\_\_

For treatment of \_\_\_\_\_

Doseage \_\_\_\_\_

To be given (**check one**) as needed, every \_\_\_\_\_ hours

at the following specific time(s) \_\_\_\_\_

Any special directions, signs to observe, side effects:

### Check One:

I am requesting the school nurse or designated school personnel to administer the medication **prescribed** by:

\_\_\_\_\_ to \_\_\_\_\_  
(Licensed Prescriber) (Student)

I am requesting that the school nurse or designated person administer this **over-the-counter (OTC)**, non-prescription drug according to the manufacturer's directions.

I give permission for exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regime.

I understand the information is confidential according to the Family Rights and Privacy Act (FERPA), and school personnel, needing to know, have access to this information. I agree to coordinate and work with school personnel and the prescriber if questions arise.

I understand I may cancel this request at any time, and/or retrieve the medication from the school at any time. I understand the medication will be destroyed if it is not picked up by myself or other designated adult within one week following termination or the order or by dismissal time on the last day of the school year.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Student \_\_\_\_\_