# North Olmsted School District

## School Medication Authorization Form

Student Name:_____ Date of Birth:_____

Grade:_____ Teacher:_____ School Year:_____

✔ Medications must be provided in the **original container** or prescription bottle.

✔ Medications must have a **current expiration date**.

☐ Birch ☐ Maple ☐ Chestnut ☐ Pine ☐ Middle School ☐ High School

**Reason for use (Medical Condition):**_____

| Medication | Dose | Time to be Given | Special Instructions | Start and End Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Name and Title of Licensed Prescriber (please print):** _____

**Licensed Prescriber Signature:** _____ **Date:** _____

**Fax:**_____ **Phone:**_____

**Parent/Guardian Authorization**

I give permission for the above medication(s) to be administered to my child by school staff, as described. I will provide the medication in the original container. I give school health staff permission to: **1)** Communicate with the child's teacher about the health condition/action of medication, **2)** Consult with the above licensed prescriber or designee regarding medication or medical condition, **3)** Release information related to the above medication and/or medical condition to the licensed prescriber or designee. I will notify the school for any changes to my child's health status, medication or licensed prescriber.

_____ _____ _____

**Parent/Guardian Signature** **Phone #** **Date**