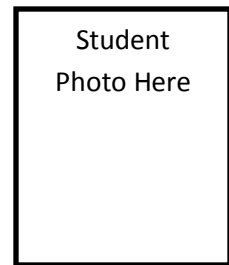


STUDENT \_\_\_\_\_  
SCHOOL \_\_\_\_\_

GRADE \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_



**Note:** Prescription Medication must be in the original container indicating the following information: student name, dosage, healthcare provider, pharmacy, date issued, and prescription number.

**PARENT STATEMENT:** I request that the prescription medication listed below be given to my child named above.

- I understand that only current medications will be given at school.
- I understand that in the absence of the school nurse, other trained school staff may administer medication.
- I agree to defend and hold the school district employees harmless from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements.
- I give permission for the school nurse to contact the health care provider regarding this treatment.
- **I will notify the school immediately if the medication is changed and understand that the nurse may contact the health care provider or pharmacist regarding this medication.**
- **I understand that this medication will be destroyed unless picked up by the end of the last student school day of this year per federal DEA requirements.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
Home phone \_\_\_\_\_ Work/Emergency Phone \_\_\_\_\_  
Other medications your child is taking \_\_\_\_\_

**HEALTHCARE PROVIDER STATEMENT:** This medication is required during school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication. The above named child should receive prescribed medication for the following condition: \_\_\_\_\_

- Medication \_\_\_\_\_
- Prescribed daily dosage \_\_\_\_\_
- Time and dosage given at school \_\_\_\_\_
- Beginning date of medication \_\_\_\_\_ Ending Date \_\_\_\_\_
- Possible side effects \_\_\_\_\_
- Special instructions for administration \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_ Date \_\_\_\_\_  
Printed Name \_\_\_\_\_ Phone \_\_\_\_\_  
Healthcare Provider Address \_\_\_\_\_

Approved or  Denied School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_  
School Administrator Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICATION AUTHORIZATION FORM – Long Term Medication (page 2 of 2)**

**E 5141.21 (c-2)**

**STUDENT** \_\_\_\_\_ **GRADE** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_ **SCHOOL** \_\_\_\_\_

Initials	Signature	Date, Amount of Med, Count Verified (Initials)				Date, Amount of Med, Count Verified (Initials)				Date, # In-coming Med	Date, # In-coming Med	Date, # In-coming Med	Date, # In-coming Med
		Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4				
		Aug					Jan						
		Sept					Feb						
		Oct					March						
		Nov					April						
		Dec					May						

**MEDICATION** \_\_\_\_\_ **DOSE** \_\_\_\_\_ **/ TIME** \_\_\_\_\_

Month \_\_\_\_\_ Month \_\_\_\_\_ Month \_\_\_\_\_ Month \_\_\_\_\_ Month \_\_\_\_\_ Month \_\_\_\_\_ Month \_\_\_\_\_ Month \_\_\_\_\_ Month \_\_\_\_\_ Month \_\_\_\_\_

Day	Time/Init.	Day	Time/Init.	Day	Time/Init.	Day	Time/Init.	Day	Time/Init.	Day	Time/Init.	Day	Time/Init.	Day	Time/Init.	Day	Time/Init.
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31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31

