Nashville Community Consolidated District # 49

Medication Authorization Form

Name of Student:____ DOB:___/___/_____ Grade:____________

<u>All</u> medication, including prescriptions and non-prescription (Tylenol, Ibuprofen, Tums, cough syrup) drugs, shall require a written order from the physician detailing:

- Name of student
- Name of the medication, indication, dosage and direction for administration
- Possible side effects and restrictions
- Emergency number where physician can be contacted

All medication shall be brought in the container from the pharmacy or in the original packaging.
All medication given at school shall require written consent from the parent or guardian.
All medication shall be stored in and dispensed from the Nurse's Office.

<u>TO BE COMPLETED BY PHYSICIAN</u>

Medication	Dosage	Route	Frequency	Indication	Side effects
1.Tylenol 2. Ibuprofen (circle preference)		PO Other:	Every ____ hours as needed	Pain or fever	

Other medications child is taking:____

______________________________________ ____________________
Physician Signature/Date **Phone Number**

I acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, I hereby authorize Nashville Community Consolidated School District #49 and its employees, to administer prescribed medication in the manner described above.

______________________________________ ____________________
Parent/ Guardian Signature **Date**

Please refer to the Medication Policy in the District #49 Handbook, website, or contact the school nurse with any questions.

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