Fredericksburg Academy
Medication Authorization

THE SCHOOL ASSUMES NO RESPONSIBILITY FOR ANY MEDICATION(S), PRESCRIPTION OR OVER THE COUNTER, ADMINISTERED BY THE STUDENT

No medication will be administered unless:

1. There is a Medication Authorization form signed by a Physician/Nurse Practitioner yearly or when there is a medication change.
2. This form is signed by the parent and designee of the school.
3. The medication is presented by the parent/guardian to the school nurse, principal or designee.
4. The medication is in the original container (Rx medications must have the label on the container).
5. There must be one Medication Authorization for each medication.

TO BE COMPLETED BY PHYSICIAN / NURSE PRACTITIONER

Name of Student:_____ Date of Birth:_____ Grade:_____

Diagnosis:_____ Medication Allergies: _____

Medication/Treatment Required:_____

Dosage:_____ Route:_____ Time/Schedule:_____

Side effects, precautions, special instructions or comments:_____

_____

Start Date: _____ End Date: _____

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I have examined the above child and determine that the above medication is medically necessary during school hours.

Physician / Nurse Practitioner Name (Please Print or Stamp): _____

Address:_____

Telephone: (_____) _____ Fax: (_____) _____

Physician/Nurse Practitioner Signature: _____ Date:_____

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STATEMENT OF THE PARENT/GUARDIAN TO BE COMPLETED BY Parent/Guardian

I am unable to personally administer the above medication to my child and no member of my family or relative is able to do so. I request, and hereby authorize, the school to administer the above medication as prescribed. I consent to the exchange of information between the physician/nurse practitioner with the school nurse regarding the medication and treatment.

_____ _____

Signature of Parent/Guardian *Date*

_____ _____

Nurse/Designee Signature *Date*

Updated: 1/15/2019