BLOUNT COUNTY SCHOOLS

Health Services

PRESCRIPTION MEDICATION AUTHORIZATION FORM

This form is to be completed and signed by the parent/guardian authorizing medication to be given to the student during school hours. This form must be completed for **PRESCRIPTION** medications and returned to the school before the medication can be given. All prescription medication must be in a current pharmacy-labeled container. If instructions for administration below are different from instructions on the label, a physician's authorization will be required. If any dosage changes occur during the school year, a new form must be completed and returned to the school. Please place each medication on a separate form. **This form is good for one school year.**

Student's Name _____ _____ _____

Last First Sex Date of Birth

_____

Physician Name Address Telephone

I request that my child be assisted in taking the medicine described below at school by authorized persons or be permitted to medicate her/himself.

_____

Date **Parent/Guardian Signature** **Home Phone** **Emergency Phone**

Diagnosis for which medication is given:

_____

Medication _____Form (Tablet, Capsule, Liquid, other_____)

Dose_____ Frequency/Time Given _____

List significant side effects of medication to watch for:

_____

Drug Allergies _____

If given "AS NEEDED", describe indications:_____

How soon can it be repeated? _____

Is student authorized/capable to medicate him/herself? Yes No

Length of time (days/weeks/months) medication to be given: _____

Student may take acetaminophen (generic Tylenol) and diphenhydramine (generic Benadryl) while on this medication. Yes No