Franklin Elementary School
Student Health Services
Fax # 530-822-5177

AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed.

STUDENT'S NAME: _____

TEACHER: _____ GRADE: _____

I hereby request that Franklin Elementary School, through the principal or designee, supervise/assist in the administering of medication to my child, _____ , according to the instructions contained on the statement below.

I understand that:

- **Medications (both prescription and non-prescription) must be in the original labeled container (no baggies, foil, etc.).**
- **Parent/guardian must provide specific instructions, as well as the medication and related equipment to the principal or clinic personnel.**
- **It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed.**
- **All medication will be taken directly to the office/clinic by the parent and/or student.**
- **Unused medication will be disposed of unless picked up within one week after medication is discontinued.**
- **School employees will not assume any liability for supervising or assisting in the administration of medication.**

*****Circle one: Prescription or Non-prescription (If prescription, have physician/health care provider complete and sign bottom portion).**

NAME OF MEDICATION: _____

DOSAGE AND TIME OF ADMINISTRATION: _____

STOP MEDICATION ON: _____
PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE:_____
I release the school board, the school, and any school employee from any liability for administering this medication.
PARENT/LEGAL GUARDIAN SIGNATURE_____DATE _____

Home Phone: _____Work Phone: _____Pager/Cell Phone: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATIONS

CONDITION/ILLNESS REQUIRING MEDICATION: _____

POSSIBLE SIDE EFFECTS, IF ANY: _____

SIGNATURE OF HEALTH CARE PROVIDER: _____ DATE: _____

To be completed by Clinic Aide/School Nurse only: