FBS Authorization for the Administration of Medication

Parents/guardians requesting medication administration to their child shall provide the school with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student: _____

Today's Date: _____

Medication Name/Generic Name of Drug: _____

Controlled Drug? YES NO (Circle one)

Condition for which drug is being administered: _____

Time of Administration: _____ Start Date: _____

End Date: _____

Dosage: _____

Method/Route: _____

Specific Instructions for Medication Administration:

_____

_____

Relevant Side Effects of Medication:

_____

Explain any allergies, reaction to/negative interaction with food or drugs:

_____

Plan of Management for Side Effects:

_____

Prescriber/Clinic Name: _____

Phone Number: _____

Parent/Guardian Authorization:

I request that medication be administered to my child/student as described and directed above. I hereby request that school personnel administer the above ordered medication. I have administered at least one dose of the medication to my child/student without adverse effects.

Parent/Guardian Signature: _____ Relationship: _____

Date _____ Home Phone #: _____

Work Phone #: _____ Cell Phone #: _____

FBS Staff Only:

_____ Authorization form is complete **_____ Medication is appropriately labeled**

_____ Medication is in original container **_____ Date on label is current**

Person Accepting Medication (print name):

_____

Signature: _____

Date: _____