ROWANTY TECHNICAL CENTER

Authorization for Medication Administration at School

With the exception of acetaminophen, ibuprofen, and naproxen, all medication administered at school shall require the completion of this authorization form by parent/guardian and licensed prescriber.

(A separate parent authorization form is required for the aforementioned medications.)

Student		PARENT/GUARDIAN	I SECTION	
principal's designee at Rowanty Technical Center administer the below prescribed medication to my child. I give the principal's designee permission to contact the licensed prescriber if necessary. In signing this form, I am agreeing to hold the school and its personnel free from any legal action that might arise from this arrangement. also understand that I am to abide by the school division regulations as stated below: It is my child's responsibility to come to the main office to take his/her medication. Personibility to come to the main office to take his/her medication. Personibility to come to the main office to take his/her medication cannot be transported on buses or by students. The first dose of a new medication should be given at home. Prescribtion medication must bring medication into school office. Medication cannot be transported on buses or by students. Prescriber medication must be in the original, unopened container, labeled with student's name. Posserption medication must be a new ritten authorization and corresponding change in the prescription label. Parent or guardian must provide medications/equipment required to administer medications or provide special medical care. Left over medication must be picked up at the end of the school year or it will be discarded. Parent/Guardian Signature	Student	DOB	Medication Allergies	
It is my child's responsibility to come to the main office to take his/her medication. Parent or guardian must bring medication into school office. Medication cannot be transported on buses or by students. The first dose of a new medication should be given at home. Prescription medication must have a current prescription label that corresponds with the written authorization below. Over-the-counter medication must be in the original, unopened container, labeled with student's name. Any changes in a medication require a new written authorization and corresponding change in the prescription label. Parent or guardian must provide medications/equipment required to administer medications or provide special medical care. Left over medication must be picked up at the end of the school year or it will be discarded. Parent/Guardian Signature	principal's des principal's des	ignee at Rowanty Technical Center administer the bignee permission to contact the licensed prescriber	pelow prescribed medication to my child. I give the if necessary. In signing this form, I am agreeing to h	old
Parent/Guardian PRINTED Name Work Phone Cell Phone Cell Phone LICENSED PRESCRIBER SECTION (Must be completed by Physician / Dentist / Nurse Practitioner / Physician Assistant) I certify that, in my opinion, it is medically necessary that the medication prescribed below be administered to (Name of Student) during school hours and that this medication may be administered by school personnel. Prescription: Medication: Dosage, Time and Route: Duration: Date of Prescription: Diagnosis Requiring Medication: Possible Side Effects: Special Handling Instructions: Prescriber Signature Date Prescriber PRINTED Name Prescriber PRINTED Name Prescriber Phone Fax Prescriber Phone Fax Prescriber Phone Fax Prescriber Phone Fax Prescriber Printed Prescriber Pr	 It is my child's Parent or gual The first dose Prescription m Over-the-cour Any changes in Parent or gual 	responsibility to come to the main office to take his/her rdian must bring medication into school office. Medication of a new medication should be given at home. nedication must have a current prescription label that conter medication must be in the original, unopened contain a medication require a new written authorization and ordian must provide medications/equipment required to a	responds with the written authorization below. iner, labeled with student's name. corresponding change in the prescription label. administer medications or provide special medical care.	
LICENSED PRESCRIBER SECTION (Must be completed by Physician / Dentist / Nurse Practitioner / Physician Assistant) I certify that, in my opinion, it is medically necessary that the medication prescribed below be administered to (Name of Student) during school hours and that this medication may be administered by school personnel. Prescription: Medication: Dosage, Time and Route: Date of Prescription: Possible Side Effects: Special Handling Instructions: Prescriber Signature Date Prescriber PRINTED Name Prescriber Phone Fax	Parent/Guardi	an Signature	Date	
LICENSED PRESCRIBER SECTION (Must be completed by Physician / Dentist / Nurse Practitioner / Physician Assistant) I certify that, in my opinion, it is medically necessary that the medication prescribed below be administered to	Parent/Guardi	an PRINTED Name		
LICENSED PRESCRIBER SECTION (Must be completed by Physician / Dentist / Nurse Practitioner / Physician Assistant) I certify that, in my opinion, it is medically necessary that the medication prescribed below be administered to	Home Phone _	Work Phone	Cell Phone	
(Must be completed by Physician / Dentist / Nurse Practitioner / Physician Assistant) I certify that, in my opinion, it is medically necessary that the medication prescribed below be administered to				
may be administered by school personnel. Prescription: Medication:	I certify that, i	(Must be completed by Physician / Dentist / n my opinion, it is medically necessary that the med	Nurse Practitioner / Physician Assistant) lication prescribed below be administered to	
Prescription: Medication:	may be admin		udent) during school nours and that this medication	ı
Dosage, Time and Route:				
Duration: Date of Prescription: Diagnosis Requiring Medication: Possible Side Effects: Special Handling Instructions: Prescriber Signature Date Prescriber PRINTED Name Prescriber Phone Fax	-			
Diagnosis Requiring Medication: Possible Side Effects: Special Handling Instructions: Prescriber Signature				
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