Greater Albany Public Schools
Authorization for Medication Administration by School Personnel

To: _____ of: _____
(Administrator's Name) (School Name)

Student Legal Name: _____ Date of Birth: _____

Grade: _____ Teacher: _____

I am giving school personnel permission to administer medications to my child per the following:

Parent or Physician to complete:

Medication: _____

☐ Non Prescription ☐ Prescription Rx # _____

Dose (how much): _____

Frequency (how often): _____

Route (circle one): Mouth Ear Eye Nose Skin

Time medication is to be administered: _____

Duration: Start date: _____ End Date: _____

Reason For Medication:

_____

_____

Special Instructions:

_____

_____

___ Please allow my child to self-administer this medication (refer to district policy on self medication).
___ Please send this medication on field trips that overlap dosage times.

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Parents are required to pick up all unused medication by the last date of school. All medication left at the school will be discarded.

_____

Parent/Guardian Signature Date

This authorization applies only to the medication listed above and for the duration of treatment or school year. This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.