BLOUNT COUNTY SCHOOLS
HEALTH SERVICES

PRESCRIPTION MEDICATION AUTHORIZATION FORM

This form is to be completed and signed by the parent or legal guardian authorizing medication to be given to the student during school hours. This form must be completed and returned to the school before the medication can be administered. All prescription medication must be in a current labeled pharmacy container. ***If instructions for administration below are different from instructions on the label, a physician's authorization is required.*** If there are any dosage changes during the school year, a new form must be completed and returned to the school. Please fill out a separate form for each medication. **This form is only valid for one school year.**

Student's Name _____ _____ _____
Last First Sex Date of birth

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

_____
Date Parent/Guardian Signature Home Phone Emergency Phone

_____
Provider Name Address Phone

Diagnosis for which medication is given:

_____

Medication_____ Form (tablet, capsule, liq, other____)

Dose_____ Frequency/Time Given_____

List significant side effects to watch out for:

_____

Drug Allergies _____

If to be given "as needed", describe indications:_____

How soon can it be repeated? _____

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

Length of time medication to be given? _____

Student may take generic tylenol, ibuprofen and generic benadryl while on this medication? Yes No

_____
Provider Signature (MD, PA, NP, etc) **Date**