Akron Central School District
Medication Authorization Form

- *Please take note that sections A and B **must** be completed in their entirety.*

A. To be completed by Parent/Guardian:

I request that my child ____________________________D.O.B. ___________ receive the medication as prescribed below by his/her physician. The medication is to be furnished by me in a properly labeled container from the pharmacy. I understand it is against school policy for a student to transport medication to/from school. An adult must bring medication and refills to the health office. All medication must be checked and verified by the Health Office. I understand that if my child is not self-directed, the school nurse or designated personnel will hold and/or administer the medication.

Signature (Parent/Guardian) ____ Date: _______________

B. To be completed by physician:

I request that my patient, as listed above, receive the following medication:

ALLERGIES: ____

Medication	Dosage	Frequency	Route

Duration of treatment: Entire school year: _______________ Other: _____________________________

Possible side effects: ____

Physician's Signature: ____Date: ___________________

Address: ____Phone: __________________

Self-Administration Release Form

We request that (Child's name) __________________________________ be permitted to carry the medication on his/her person, or to keep the same in his/her locker, P.E. locker, or backpack, as we consider him/her to be responsible. He/She has been instructed in and understands the purpose of and appropriate method and frequency of its use.

Please read carefully: The physician and the parent/guardian MUST complete both sections of this form for those students who request permission to carry his/her own medication in school. **THE STUDENT WILL NOT BE CONSIDERED SELF-ADMINISTERING UNTIL THE HEALTH OFFICE HAS REVIEWED THE GUIDELINES FOR MEDICATION ADMINISTRATION WITH HIM/HER, AND IT HAS BEEN SIGNED OFF BY THE HEALTH OFFICE. THE FINAL DECISION ON A STUDENT'S ABILITY TO BE SELF-ADMINISTERING IS THAT OF THE SCHOOL NURSE.**

Prescribing Physician's Signature: ____**Date:** ________________

Parent/Guardian's Signature: ____**Date:** _________________

Student's Signature: ____**Date:** _________________

School Nurse's Signature: ____**Date:** _________________