School Medication Authorization School Year _____

Student _____ Date of Birth _____ Grade _____

Parent/Legal Guardian _____ Phone # _____

To be completed by Health Care Provider

* One form to be completed per medication

Medication _____ Dosage _____ Route _____

Time(s) to Administer _____ Start Date _____ Stop Date_____

Reason for Medication _____

Side Effects/Precautions _____

Provider Signature _____ Date _____

Print Name _____ Phone _____

To be completed by Parent/Guardian

Allergies _____

Medical History/Diagnoses _____

Current Medications _____

My signature in the space below assures that:

1. I hereby give my permission for my child (named above) to receive this (stated) medication at school.
2. I assume full responsibility and will inform school staff of any medication changes or health status
3. I hereby release Booneville School District and employees from any and all liability that may occur as a result of medication administration.
4. I will provide a new medication form each school year and each time the dose/medication changes.
5. I agree to furnish medication in the original, properly labeled pharmacy or store container.
6. I will pick-up any unused/discontinued medications as indicated during (or by end of) the school year.
7. I understand that if the school nurse is not available a trained unlicensed school personnel will administer this medication.

Signature of Parent/Guardian _____ Date _____

To be completed by School Nurse

Sarah Beth Maness, RN
Booneville Middle School/Booneville High School
Email: smaness@boonevilleschools.org

Tori Pounds, RN BSN
Anderson Elementary School/NEMRAEC
Email: tpounds@boonevilleschools.org

List staff trained to administer this medication _____

Signature of School Nurse _____ Date _____