Parent, please complete each section, sign and return form to the Main Office at your child's school.

Authorization for Medication Administration

I hereby give permission for my child, _____ to receive medication during school hours. As the parent/guardian, I assume the responsibility of any adverse reactions this medicine may cause for my child. I agree to bring the prescribed medicine in a container properly labeled by a pharmacist. Nonprescription medicine will be brought in a sealed, original container with student's name written on container.

Signature of Parent or Guardian _____ Date _____

Home telephone number _____ Work telephone number _____

Emergency Contact _____ Emergency telephone number _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION good for _____school year.

I hereby authorize (physician's name)_____ to release to the school nurse or principal, specific, confidential medical information contained in his/her record about my child. This information will be used by school staff to deliver health care services to my child in school.

Child's Name: _____ Birth Date_____

To: _____ _____ _____

Name of School Date Parent/Guardian's Signature

AUTHORIZATION TO FAX MEDICAL INFORMATION

I give permission for the school to fax this Medication Record to my child's health care provider (if needed). I give permission for my child's health care provider to fax this form back to the school. I understand the school cannot guarantee the confidentiality of the fax machine.

_____ _____

Signature of parent or guardian Date

Medication Check-In/Check Out Log

Date/Time	Medication/Dose	Amount on Hand	Amount Received	Total	Received by (Signature)	Signature of Witness

Medication Returned to Parent/Guardian

Date	Medication	Amount	Parent/Guardian Signature	Signature of Witness

Medication Disposal/Destroyed Log (If not picked up)

Date	Medication	Amount	Signature of RN	Signature of Witness