HOPKINS PUBLIC SCHOOLS
HEALTH SERVICES

Authorization for Administration of Medication at School

Parents/guardians asking school staff to give medications to their child must provide (written) permission from themselves and the health care provider every school year.

Student:_____ Birth date:_____ Grade:_____

School:_____ School year:_____

Allergies:_____

Medical Condition	Medication	Dose	Time	Route	Possible Side Effects
1.					
2.					
3.					
4.					

Start date: _____ Stop date: _____
(**Authorization expires at the end of the school year or following the summer school session**)

_____ _____ _____
Signature of Physician/Licensed Prescriber Print name of Physician/Licensed Prescriber Date

_____ _____ _____
Clinic address Phone Fax

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request that the medication be given on field trips as prescribed.
2. I will notify the school of any change in the medication(s), (i.e. dosage change, medication is stopped, etc.)
3. I give permission for the school nurse to communicate as needed with school staff about my child's health condition(s) and the action of the medication(s).
4. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).

Parent/Guardian signature Date Relationship to Student

NOTE: MEDICATION IS TO BE SUPPLIED IN THE ORIGINAL PRESCRIPTION BOTTLE