



Ada City Schools

School Health Services

ACS Health Services
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Authorization for Administering Prescription Medication

Every effort should be made to give medications at home. However, if your child must take a non-prescription medication at school, compliance with the following instructions is required.

Student's Name: _____ DOB: _____ Grade: _____

Parent/Guardian: _____ Relationship: _____

Phone: _____ Work Phone: _____

Emergency Contact - Name and Phone Number: _____

Physician's Name: _____ Phone Number: _____

This form must be completed by parent/guardian and the student's physician before a prescription medication will be administered.

*A new form must be completed for each change in medication and renewed each school year. The pharmacy should prepare a bottle for school with the following information: Child's Name, Medication, Dosage, Frequency, Directions for Administering, Doctor's Name, and Date Filled. Medication not sent in original bottle or container and properly labeled will **NOT** be given.*

To Be Completed By Parent/Guardian:

I, the undersigned parent/guardian, request that a designated school employee administer to my child the following medication. I also understand the school nurse may contact the physician as needed and medication information will be shared with school personnel who have a need to know.

Name of Medication and Dosage: _____

Times To Administer: _____

Date

Parent/Guardian Signature

To Be Completed By Physicians:

The above named student is currently under my medical care, and has a medical condition that requires him/her to take prescription medication daily during school hours.

Reason/Purpose: _____

Name of Medication and Dosage: _____

Directions for Administering, Including Time: _____

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

List significant side effects: _____

Length of time medication is to be given: _____

Date

Physician's Name

Physician's Phone

Physician's Signature

A photo copy or fax copy of this form is valid.