



Medication Authorization Form

Student's Name _____ Date _____

Teacher _____ Grade _____

Name of Medication _____ Dose _____

Route to be administered (circle one): by mouth inhalation topical injection

Time to be administered _____

This medication is needed for _____

If medication is to be given as needed, please describe symptoms:

Discontinuation Date (if applicable) _____

It is helpful if medication is administered at home rather than at school whenever possible. If medication from home must be administered at school, parents are required to sign this medication authorization form and send the medication in its original, pharmacy labeled container. Over the counter medication must be sent in the original packaging.

I understand that my child will be assisted in taking the medication(s) described above at school by the school nurse or authorized person(s) at the nurse's station. The undersigned agrees to release, indemnify, and hold harmless CMDS, its employees, or representatives from any claim, liability, or expense arising out of or in any way connected with the giving or failure to give prescribed medication to my child. This release and indemnity agreement includes claims based on alleged negligence on the part of CMDS or its employees. In addition, I agree that it is my responsibility to inform the school and my child's teacher, in writing, of any change in medication and/or its distribution to my child.

Parent's Name _____ Signature _____

Street Address/City/Zip _____

Phone Numbers _____

Emergency Contact/Phone _____