

Pulaski County Public Schools  
**MEDICATION AUTHORIZATION FORM**

Please complete a separate form for each medication to be given during school hours, on field trips, and/or after school activities. Whenever possible please have medication given at home. Any medication that is to be given at school must be brought to school by a parent/guardian, **not** the student.

Student Name:		DOB:
School:	Grade:	Teacher:
Medication Allergies:	Diagnosis or Condition being treated:	
Name of Medication:		
Dosage:	Form/Route of Administration:	Time(s) of Administration:
If Medication to be given "when Needed" describe indications and how often it can be repeated:		
List significant side effects/adverse reactions to be reported to doctor:		
Start Date:	End Date:	In addition, this medication must be taken on: (circle) Field trip      Overnight field trip
For morning medications: who will administer in case of a school delay? <b>(Please circle)</b>		
1-hour delay:	Parent	School Staff
2-hour delay:	Parent	School Staff

***A licensed prescriber's signature is required for all prescription and over-the-counter medications that will be given at school.***

Date:	Physician/Licensed Prescriber Signature:
Phone:	Address:

I request that authorized school personnel assist my child in taking the medication described above while at school. I have read and accept the medication guideline for PCPS. I authorize the school nurse to share information regarding this medication with the licensed prescriber signing above. I understand the PCPS Board and its employees are not responsible for the effects of the medication administered. Physician/Licensed Prescriber will be notified of any request to withhold, discontinue or change the dose of the above medication.

Date:	Parent/Guardian Signature:	
Home Phone:	Work Phone:	Emergency Phone: