DICKINSON PUBLIC SCHOOLS

Dickinson Public Schools
Medication Administration Authorization
Preschool/Elementary Schools

Implemented 11/2023

Office Use Only
School Year:
Alert in PS:
Date Discontinued:

Directions for Parents/Guardians: Please complete this form if you want DPS staff to administer prescription or non-prescription medications to your child.(Exception: reliever inhalers and EpiPens) (1) This form must accompany each medication to be administered; (2) This form must accompany each new medication or change in dosage/time of day that may occur during the school year; (3) Physician signature is required for all prescription medication and over the counter medication (when the dose given is different than the recommendation on the box); and (4) All types of medications must be in their original containers and labeled with child's name. An adult must deliver your child's medication to school staff or it cannot be accepted. Thank you for your cooperation!

Name of Student:	**DOB:**	**Teacher/Grade:**
Name of Medication:	**Dose:**	**Time/Frequency:**
Route (Circle one): By Mouth Inhaled Nasal Apply to Skin Eyes Ears Injection		
Reason for Medication:	**Start Date:**	**End Date:**
Instructions for Use:		
Major Side Effects:		
Other Information Staff Should Know about Student and this Medication:		
Prescribing Physician (print):		**Phone #:**
Physician's Signature:		**Date:**

Authorization:

- I give permission to Dickinson Public School personnel and/or medical personnel, designated by the School District, to administer this medication. I understand that administration of this medication will not necessarily be done by a nurse.
- I will notify the school immediately if my child's health status changes or this medication is discontinued.
- I understand that expired medication will not be given and will ensure that all medications are current and up to date.
- I give permission to School personnel and designated medical staff to dispose of medications at the end of the school year if I have not picked them up.
- I give permission to School personnel and designated medical staff to contact the healthcare provider as needed; and that medication/health information may be shared with staff that needs to know.

I have read and understand the "Directions" and "Authorization" sections listed above. I authorize school personnel (and medical personnel designated by the District) to administer this medication to my child.

Name of Parent/Guardian (please print) Daytime Contact Phone Number

Signature of Parent Today's Date

Medication Administration Documentation

Short Term Medication

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials	Signature

Date	Comments