

Central Decatur Community School
Parental Authorization and Release Form for the Administration of
Student Prescription Medication/Health Service

_____/_____/_____
Student Name (Last, First Middle) Birthday School Bldg Date

School medications and health services are administered following these guidelines:

- Parent has provided a signed, dated authorization to administer medication and/or provide the health service.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student's name, name of the medication, directions for use, and date.
- Authorization is renewed annually and immediately when the parent notifies the school that changes are necessary.

Medication/Health Service Dosage Route Time at school

Administration Instructions

Special Instructions and Possible Side Effects

_____/_____/_____
Prescriber's Name Date Discontinue/ReEval/Follow-up Date

Prescriber's Address Emergency Phone

I request the above student receive medication/health service at school and school activities, according to the prescription, instructions, and a written record be kept. Special considerations are noted above. The information is confidential except as provided to the Family Education Rights and Privacy Act (FERPA). I agree to coordinate and work with school personnel and prescriber when questions arise. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment. School staff may contact the prescriber as needed.

Parent Signature Date

Parent Address Home Phone

Additional Information Business Phone