



## AUTHORIZATION/CONSENT FOR MEDICATION/TREATMENT AT SCHOOL

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School Year \_\_\_\_\_

Diagnoses/Condition: \_\_\_\_\_

### CONSENT FOR ADMINISTRATION OF HEALTH TREATMENT AND/OR MEDICATION AT SCHOOL

- Parents are urged to provide health treatments and give medication at home and on a schedule other than school hours if possible. If it is necessary that treatments and/or medication be provided during school hours, these regulations must be followed. *Please note: "Medication" refers to any prescription, non-prescription, homeopathic, herbal, vitamin, or mineral preparation.*
- Health treatments and medications must be prescribed in writing by a physician or other licensed health care provider and must be renewed at least annually. Providers complete Part 1 below and must sign form- Part 2 and fax written instructions to school.
- All medication, prescription and non-prescription, must be brought to school in the original pharmacy container with a current label showing the name of the student, medication strength, dosage, and time(s) to be given. Only the parent/guardian or other responsible adult or the pharmacy may deliver the medicine to school. Students are not allowed to bring their own medication to school.
- Health treatment supplies will be provided for school use for each student by parent/guardian as needed.
- Parent/guardian written permission is required to administer treatments and medications at school as directed by physician/licensed health care provider, including permission to contact provider as necessary. Parent must sign below-Part 2.

### PART 1: PHYSICIAN/HEALTH CARE PROVIDER INSTRUCTIONS

Medication/Treatment: \_\_\_\_\_

Strength/Dosage/Route \_\_\_\_\_

Time(s)/Frequency to be given at school: \_\_\_\_\_

Desired action of medication: \_\_\_\_\_

Student can self-carry the prescribed medication ☐ (check box if yes)

Recommendations, Special Considerations, Side Effects, Precautions, Allergies:

### PART 2: AUTHORIZATION SIGNATURES

The following signatures serve as written authorization for permission to administer health treatment and/or medication as directed at school. Authorization includes permission for school personnel and healthcare provider to contact each other if needed. Medication and Treatment information is kept confidential but it may be share with appropriate staff for emergency care. I will not hold the CPS Board of Education or it's personnel responsible for complications related to the medication. Medication that is not picked up by the last day of school will be disposed of at local pharmacy or local police department for controlled substances.

Physician/Provider: \_\_\_\_\_  
Print Name Signature

\_\_\_\_\_  
Date Phone Fax

Parent/Guardian: \_\_\_\_\_  
Print Name Signature

\_\_\_\_\_  
Date Phone Fax

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