

**URBANDALE COMMUNITY SCHOOLS**

**AUTHORIZATION TO ADMINISTER MEDICATION TO STUDENTS**

Medication (prescription and over-the-counter) to be administered at school will be done under the supervision of the Health Facilitators by qualified staff.

The medication needs to be sent to school in its original container with the prescription label, or manufacturers label, clearly visible.

A request to administer the medication must include the student's name, name of the medication, dose, and dates and time to be given.

Student\_\_\_\_\_ Age\_\_\_\_\_ Grade\_\_\_\_\_

Medication\_\_\_\_\_ Dosage\_\_\_\_\_

Time to be given at school\_\_\_\_\_ Route\_\_\_\_\_ (oral, inhaler, drops, etc.)

Date to begin\_\_\_\_\_ Date to end\_\_\_\_\_

Physician/Dentist\_\_\_\_\_ Phone\_\_\_\_\_

I request that the above medication be given according to these written directions.

I give the school nurse permission to contact the physician or dentist as needed.

I understand that all medications need to be picked up at the end of the school year or they will be destroyed.

I further understand that all health information is confidential and may be shared only on a professional basis with school personnel when deemed necessary.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone