MONROE COUNTY
COMMUNITY SCHOOL CORPORATION
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AUTHORIZATION FOR ADMINISTERING MEDICATIONS – Form 5330AG

(THIS FORM MUST ACCOMPANY ALL MEDICATION)

SCHOOL YEAR: 20____ - 20_____

PART A- TO BE COMPLETED BY PARENT/GUARDIAN

STUDENT INFORMATION

Student: _____ Birthdate: ____/____/____ School: _____Grade: _____

PARENT/GUARDIAN AUTHORIZATION

This authorization is valid only for the school year specified above. A new Medication Authorization Form must be completed for each school year, for each medication, and each time there is a change in dosage or time medication is given.

- All over-the-counter medication must be in the original container, labeled with the student's name
- Prescription medications must be in original container with pharmacy label
- Not more than a 30 day supply of medication may be delivered to the school
- Parent/guardian will transport medication to and from school
- All medication must be FDA approved (see MCCSC Guideline 5330 regarding CBD oil)

I give permission for the Health Services staff, and any pertinent staff caring for my child to administer this medication, contact my child's care provider regarding this authorization, and for this form to be faxed/emailed to my child's school or be shared with school staff within FERPA guidelines. I understand these requirements are based on MCCSC Medication Administration Guideline 5330.

I assume full responsibility for providing the school with this medication. I understand that students may only self-carry **emergency medications** while at school (i.e. inhaler, epinephrine auto-injector/Epi-Pen). All other medications must be kept in the school Health Office.

_____ _____ -_____ -_____ ____/____/____

Parent/Guardian Signature *Phone Number* *Date*

OVER-THE-COUNTER MEDICATION INFORMATION

Name of Medication: _____ Dose: _____ Route: _____

Time medication is to be given: _____ Frequency: _____ If "as needed", list reason to give: _____

PART B- TO BE COMPLETED BY HEALTH CARE PROVIDER

*only complete this section if the medication is a prescription, an over-the-counter medication that needs to be given at a higher dose than listed on the label, or the student will self-carry the medication while at school.

PRESCRIPTION MEDICATION INFORMATION

Name of Medication: _____ Dose: _____ Route: _____

Time medication is to be given: _____ Frequency: _____ If PRN, list reason to give: _____

Medical Diagnosis: _____This is an emergency medication that student has permission to self-carry: YES NO

_____ _____ _____-_____-_____ ____/____/____

Physician's Name (print/type) *Physician Signature* *Phone Number* *Date*

_____ ____/____/____

MCCSC Travel RN Signature *Date*