Jefferson County School District 509J
UNITE. ENGAGE. SOAR.

AUTHORIZATION FOR MEDICATION ADMINISTRATION
By JCSD 509-J Personnel

School_____

1.	Legal First Name	Legal Last Name	
	Birth Date	**Grade**	**Teacher's name (for K-5 students)**
	Month Day Year		

Please read the following statements and provide your initials as an approval or acknowledgement. Student may complete if 15 years of age or older.

2. **All medication must be in its newest original container with accurate labeling.** _____ Initials

3. Parent/guardian or Student is responsible for providing needed medication and maintaining the supply as needed. _____ Initials

4. Parent/guardian or Student is responsible for picking up all unused medication by the last day of school unless otherwise specified. All medication left at the school will be discarded. _____ Initials

5. Parent/guardian or Student accepts responsibility of notifying the school nurse or the school's main office staff **in writing** of any changes to the student's medication during the school year and after the date shown on this document. Changes to the prescription label or container directions must be in writing from the healthcare provider. _____ Initials

6.	Medication Name	Type	If the medication is prescription, please provide the RX number
		☐ Non-prescription ☐ Prescription	
	Start Date	**End Date**	**Time of Day to be Administered**
	Month Day Year	Month Day Year	

Dose (how much)	Frequency (how often)	Route
		☐ Mouth ☐ Ear ☐ Eye ☐ Nose ☐ Skin ☐ Inj.

Reason for Medication	Special Instructions

7. **Parent/Guardian or Student Signature (if 15 years of age and older) of Authorization**

I verify that the above health information is accurate and complete, and I understand that it is my responsibility to notify the school office in writing promptly of changes to this information. This authorization applies only to the medication listed above and the duration of treatment or school year. This authorization provides permission to exchange information, as necessary, between the school nurse, school staff, and/or my student's health provider.

Parent/Guardian or Student Signature: _____ **Date**: _____

Parent/Guardian or Student Printed Name: **Telephone:**

8. **Physician Direction** *For any non-prescription medication that is non-FDA approved*

I understand that the above medication is not FDA approved and therefore requires this written and signed order from an approved provider. My signature affirms that this medication is necessary for the above-mentioned student to remain at school.

Provider Name (printed): _____ **Date:** _____

Provider Signature (or stamp): **Telephone:**

Medication Count Log – Office Use Only

Student Name	Medication

Date	Time	Amount Received	Amount Administered	Staff Signature(s)

*Two signatures required for original amount received and refills afterward (can be with parent or staff). If medication is being transferred to teacher for field trip, both office and teacher signatures are required at check out and again upon check in.