PRESCRIPTION / NONPRESCRIPTION
MEDICATION AUTHORIZATION 2019-2020

Students Name: _____ DOB: _____

Allergies: _____

I am the parent with legal custody or the legal guardian of the above-named student who attends Jefferson West Schools. I am requesting that the following medication be administered to my child. I certify that my child has previously had at least one does of the medication and had no adverse reaction. I give my consent and authorize the school nurse, principal, or other designated school employee to administer the medication according to the prescription label and/or doctors written order. I give permission for information on this page to be shared with appropriate educational and office staff as deemed necessary by the school nurse or building principal for the safety and well-being of child.

I acknowledge that I have been given a copy of the Jefferson West Schools' Policy on Medication Administration. I understand that medication must be brought to school in the original container appropriately labeled with students name and that this request is valid for the current school year only. I understand that prescription medications must be labeled by the pharmacy or physician including the student name, date, medication name, dosage, and the number of days to be administered.

Parent/Guardian Signature: _____ Date: _____

PRESCRIPTION MEDICATION:

☐ Administer Per Prescription Label	☐ Administer Per Attached Doctor's Order
Name of Medication:	
Dosage to be Administered:	Time to be Administered:
Reason to be Administered:	
Name of Physician:	Expiration Date of Medication:

NONPRESCRIPTION MEDICATION:

☐ Administer Per Label Instructions	☐ Administer Per Attached Doctor's Order
Name of Medication:	
Dosage to be Administered:	Time to be Administered:
Reason to be Administered:	
Expiration Date of Medication:	

***Homeopathic, Herbal, Essential Oils, and other natural remedies will not be administered by Jeff West USD 340 employees.**

School Nurse: _____ Date: _____

MEDICATION DOCUMENTATION
MUST BE COMPLETED AT TIME OF MEDICATION ADMINISTERATION

Student Name:	**Grade:**
Medication Dosage, Time, Route:	
Care Provided By:	
_____ _____	_____ _____
_____ _____	_____ _____
_____ _____	_____ _____

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