Parent/Guardian Authorization to Administer Medication at School		
The parent/guardian of	Name) Grade:	requests that the staff at
	Name) ister the following medication to my child, ac	
(School Child Attends) signed instructions on the lower part of this form:		
-	Dosage/Amount:	Time(s):
Prescription medication must come in a container labeled with the child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.  Over the counter medication must be labeled with the child's name. Dosage must match the signed health care provider authorization below and medicine must be packaged in the original container.  Littleton Public Schools agrees to administer medication prescribed by a licensed health care provider.  For safety reasons, parents are requested to bring the medication directly to the school office.		
<ul> <li>Unused medication that is not picked up by the parent will be discarded one week after the end of the school year.</li> <li>New medication authorization forms must be completed each time there are any changes in medication or dosage, and at the beginning of each school year.</li> <li>It is understood that medication is administered solely at the request of, and as an accommodation to, the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by any personnel employed by Littleton Public Schools, the undersigned parent</li> </ul>		
or guardian hereby agrees to release the said institution and their personnel from any legal claim(s) which they now have, or may hereafter have, arising out of the administration of (or failure to administer) the medication to the student.  By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the school nurse or school staff delegated to administer medication.		
Parent/Guardian's Name (Print)	Parent/Guardian's Signature	Date
Work Phone	Home Phone	
Health Care Provider Authorization to Administer Medication at School		
Child's Name:		Birth date:
Medication:		
Dosage/Amount:		Route
To be given at the following time(s):		
Special Instructions:		
Purpose of medication:		
Side effects that need to be reported:		
Starting Date: Ending Date: Storage Requirements:		
Signature of Health Care Provider w	ith Prescriptive Authority I	License Number
Print name of Health Care Provider	Phone Number	Date
Please ask the pharmacist for a separate labeled medication bottle to keep at the school		
For Office Use Only: (Initial & date)  Parent authorization signed  Medication log completed	Health Provider authorization signedMedRN signature and	l label & dosage matches all written authorizations date 5/08