TCCA Student Medication Authorization

When possible, medications should be given to the student before or after school by the parent/guardian. Medications to be given at school should be accompanied by this form. Prescription medication or a variation from the recommended does on over the counter medications requires this Permission for prescribed medication form. Medications should be in their original bottle, labeled with students name, medication name, dosage and prescribing physicians name. If medication is expired, it will not be administered. No more than a 30 day supply for a prescription medication may be brought to the school. Any time there is a change in a medication a new form will be required.

Students Name	Date of Birth	Grade

Medication:	Dosage:	Route:
Purpose of Medication:		
Time of day medication is to be given at School:		Frequency (i.e. daily):
Anticipated Number of days medication will be given at school: ☐ Until the end of the current school year ☐ ______________ weeks ☐ ______________ days		Is the medication a controlled substance? ☐ YES ☐ NO
		Allergies:

Health Care Provider Authorization (for prescriptions only)

Health Care Provider's Signature (Required if Prescribed medication):	Date:
Insert Provider's Name and Address Stamp Below:	Office Phone Number:
	Office Fax Number:

Parent Authorization

I give permission for my child to be given the above medication as prescribed. I give permission for the school nurse or school administrator to contact the health care provider named above or the pharmacist who filled the prescription to discuss the medication and my child's health. I give permission for the health care provider named above, the pharmacist and/or a designated employee to provide information about this medication and my child's health to the school nurse or school administrator. I understand that the school has a written medication policy and by signing below, I agree to adhere to it. I will not hold the school, church, or school personnel liable for any adverse drug reactions when the medication is administered according to the prescribed methods. I will notify the school if my child's medications change.

Parent/Guardian Signature	Date
Printed Name of Parent/Guardian	Phone Number