

**HAMPTON-DUMONT COMMUNITY SCHOOL**  
**Parent Authorization for Medication**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Student's Name (Last) (First) (Birthdate) (Grade) (Date)

School medications and health services are administered following these guidelines:

- Parent has provided a signed, dated authorization to administer medication and/or provide the health service.
- The medication is in the original labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student name, name of the medication, directions for use and date.
- Authorization is renewed annually and immediately when changes occur.

Medication	Dosage	Route	Time to be given
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\_\_\_\_\_  
Special directives, signs to observe, potential side effects

\_\_\_\_\_  
Discontinue/Re-evaluate/Follow-up date

\_\_\_\_\_  
Prescriber/Clinic/Address

I request the above student receive medication at school and school activities by qualified staff, according to the prescription, nonprescription instructions, and a written record kept. Special considerations are noted above. The information is confidential according to the Family Education Rights and Privacy Act (FERPA) and school personnel with a need to know have access to the information. I agree to coordinate and work with school personnel and prescriber when questions arise. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date