



Prescription Medication Authorization Form - Must Be Signed Every Year By a Provider and a Legal Representative of the Student

To be Completed by Student, or if Under 18, Legal Representative of the Student (Parent/Guardian):

Student Name: _____ DOB: _____

Student or, if under 18, Parent/Guardian initial the following:

___ (Initial Here) I attest that I/my child am/is either supervised (formerly called self-directed) or independent in taking my/their medication in school, meaning they can recognize and self-administer medication without assistance. I understand medication must be kept securely and must be taken as ordered. The school Health Office may store medications on my behalf under certain circumstances.

___ (Initial here) I will maintain the medication in the original pharmacy container or original packaging (if over-the-counter).

___ (Initial here) I understand that if I store medications in the School Health Office that I must pick it up at the end of the semester. I understand if I do not pick it up it will be discarded, per NY State Law.

Student or Guardian Signature: _____ Date _____

Print Name _____ Telephone _____

This Section Is To Be Completed By Health Care Provider-Valid until the end of the current school year.

Medication	Dosage	Route	Time	Diagnosis	Side effects

Provider: By signing below, I attest that I have determined this student is consistent and responsible in taking their own medications as a Supervised (formerly Self-Directed) or Independent person. They will be considered independent in medication management and may have assistance to maintain safe school protocols and during emergencies.

Provider Stamp:

Prescriber's Signature _____ Date _____

Prescriber's Name (Print) _____ Phone _____