CLEVELAND METROPOLITAN SCHOOL DISTRICT

Medication Authorization Form for Prescribed Medication

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

STUDENT INFORMATION		
Student Name	Student's Date of Birth	**For School Use Only**
		Date Received/Receiver's Signature: Medication Received? Yes No
School Name	Lunch Period	Date Approved/Nurse's Signature:
		Entered by RN? Yes No

MEDICATION INFORMATION			
Medication	Dose	Route	Frequency
Diagnosis/Reason for taking medication			
Start Date	End Date		
Possible side effects:			
Controlled Substance? YES NO			
Special instructions:			
☐ Is student capable and responsible for self-administering this medication. ***(For recuse Asthma inhaler, Epinephrine injectables and Diabetic medications only)*** No Yes (SUPERVISED) Yes (UNSUPERVISED, please complete a self-carry form)			

PRESCRIBING HEALTH PROFESSIONAL	
Signature	Date
Printed Name	
Phone	Fax

To Be Completed by Parent/Guardian

I give permission for my child, _____, to receive the above medication at school according to the CMSD policy. It is understood that the CMSD and all its school personnel are absolved from any responsibility, which might be associated with the administration of such medication. It is also understood that by requesting CMSD personnel to administer medication to my child that I also allow the prescriber to communicate with the school nurse regarding my child's treatment plan.

Signature:		Date:
Parent/Guardian Information:	Printed Name:	
	Adress:	
	Home Phone:	Cell Phone:
	Work/Emergency:	Email address

Reviewed by RN	Printed Name:	Date Reviewed: