Carman-Ainsworth Community Schools
Authorization to Administer Medication at School
Required for all Prescription and Non-Prescription Medication

School:  ○High School 591-3240/591-3215 (Fax)  ○Dillon Elem 591-3590/591-3835 (Fax)
          ○Middle School 591-3500/591-3594 (Fax)  ○Dye Elem 591-3229/591-3310 (Fax)
          ○Atalntis Alt. 591-3276/591-3265 (Fax)  ○Randels Elem 591-3250/591-3225 (Fax)
          ○C-A/Baker Career 766-2236/766-2248 (Fax)  ○Rankin Elem 591-4605/591-8440 (Fax)

Student’s Name_________________________________________  DOB _____/_____/_______
Teacher/First Hour_______________________________________  Grade______________

To be completed by Physician

Name of Medication:___________________________________________________________________________
Reason for Medication: (Optional)______________________________________________________________
Form of Medication:  ○Tablet/Capsule  ○Liquid  ○Inhaler  ○Injection  ○Nebulizer  ○Other__________
Instructions: (frequency/time and dose)_________________________________________________________
Possible side effects:  ○None Anticipated  ○Yes, explain____________________________________________
Special storage:  ○None  ○Refrigerate  ○Other_____________________
Start Date:  ○Once both medicine and completed form are received  ○Other date_______________
Stop date:  ○End of school year  ○Other date_______________

Self-Administration
This student is capable and responsible for carrying and self-administration of this medication:
 ○Yes  ○No  ○Yes, with supervision (may self-administer, medication to remain with staff)

Physician Signature_________________________________________  Date__________________
Physician Name_____________________________________________  Phone__________________

To be completed by Parent/Guardian

I request that (student’s name)_________________________________________ receive the above medication according to
school policy. I give permission for exchange of verbal and written communication between the physician and the school
nurse and/or designated school staff regarding my child’s medication. I request that my child be assisted in taking the
medication described above or be permitted to carry and self-administer as authorized by the physician above.

Parent/Guardian Signature_________________________________________  Date__________________
Parent/Guardian Name_____________________________________________  Phone__________________

*One Authorization to Administer Medication form must be filled out for EACH medication the student may take at school.
*Additional forms available at any school office or from the district nurse.

For Office Use Only
○Parent signed  ○Dr. signed  ○Med received and/or ○Student carries(labeled)
Updated/Reviewed April 2017