

## ALABAMA STATE DEPARTMENT OF EDUCATION SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

|   |                                      | •                          | School Year   |
|---|--------------------------------------|----------------------------|---|
|   | STUDENT INFO                         | RMATION                    |   |
| Student's Name:   |                                      | School:                    |   |
| Date of Birth:  | Age: Wt.:                            |                            | Teacher:  |
|   | Allergies (please list)              |                            |   |
| 110 11110 1111 111 111 111 111  | ,e.g.ee (p.easee.,                   |                            |   |
| PRESCRIBER  | AUTHORIZATION (To be com             | pleted by licensed hea     | ılthcare provider)  |
| Medication Name:  |                                      | Dosage:                    | Route:  |
| Frequency/Time(s) to be given:  |                                      | Start Date:                | Stop Date:  |
| Reason for taking medication:   |                                      |                            |   |
| Potential side effects/contraindi   | cations/adverse reactions:           |                            |   |
| Treatment order in the event of   | •                                    |                            |   |
| SPECIAL INSTRUCTIONS:   | auverse reaction.                    |                            |   |
| Is the medication a controlled su   | uhstanso2                            | ☐ Yes ☐ N                  | 0   |
| Is self-medication permitted and recommended?   |                                      | □ Yes □ No                 |   |
| • If "yes" I hereby affirm this student has been instructed on the proper self-administration of the prescribed medication. |                                      |                            |   |
|   |                                      | • •                        | •   |
| Do you recommend this medica  | , , ,                                |                            |   |
| Cake Icing Gel ONLY FOR Diabeti   | •                                    |                            |   |
| Printed Name of Licensed Healthcare Provider:  Signature of Licensed Healthcare Provider:                                   |                                      |                            |   |
| Signature of Licensed Healthcar   | e Provider.                          |                            | Date  |
|   | PARENT AUTHO                         | ORIZATION                  |   |
| _   | he above medication in accordance wi | th the administrative code | to delegate to unlicensed school personnel practice rules. I understand that additional |
| · · · · · · · · · · · · · · · · · · ·   | ne, prescriber's name, name of me    |                            | stant. Prescription medication must be<br>stervals, route of administration and         |
|   |                                      | or Trained Medication A    | ssistant. OTCs must be in the original,   |
|   |                                      |                            | thout written authorization from an   |
| authorized licensed healthcare pro  | -                                    |                            |   |
| Parent's/Guardian's Signature:  |                                      | -                          |   |
| . 3   |                                      |                            |   |
|   | SELF-ADMINISTRATION                  | AUTHORIZATION              |   |
| (To be completed ON   | ILY if student is authorized for cor | nplete self-care by licens | sed healthcare provider.)   |
|   |                                      |                            | n that he/she has been instructed in  |
| proper self-administration of the pr  |                                      | = : :                      |   |
| school, the agents of the school, an  | _                                    | inst any claims that may   | arise relating to my child's self-  |
| administration of prescribed medication(s).   |                                      | <b>D</b> - 1 -             | Dhana   |
| Parent's/Guardian's Signature:  |                                      | Date:                      | Phone:  |