Tucson School for the Blind

School Medication Administration
Authorization and Staff Training Verification

Student Information

Student Name: _____
First *Middle* *Last*

Date of Birth: _____/_____/_____ Grade: _____ School Year: _____

Classroom Teacher: _____

Parent / Guardian Name:_____

Medication Information

Medication Name: _____

Dosage: _____

Route (circle one): Oral / Inhaled / Topical / Eye / Ear / Injection / Other: _____

Time(s) to be Administered at School: _____

Special Instructions: _____

Possible Side Effects or Reactions: _____

Parent/Guardian Authorization

I authorize the school staff members listed below to administer the medication identified on this form to my child while at school or during school-sponsored activities, in accordance with the instructions provided.

Staff Member Names: _____

_____

_____

_____

_____

_____

Parent / Guardian Name: _____

Parent / Guardian Signature: _____ Date: _____

Parent/Guardian Verification

I certify that I have trained the designated staff members listed regarding the safe administration of my child's medication and grant them permission to administer the medication as described on this form. Staff members have recieved all pertinent information regarding the following:

_____ (Initial) The purpose of the medication.

_____ (Initial) The correct dosage and method of administration.

_____ (Initial) Proper storage and handling requirements.

_____ (Initial) Potential side effects and signs of an adverse reaction.

_____ (Initial) Any special precautions or emergency procedures.

I understand that:

- Medication must be supplied in its original, properly labeled container unless otherwise approved by school policy.
- I am responsible for notifying the school of any changes to the medication or dosage.
- This authorization remains in effect until the end of the current school year unless revoked in writing or replaced by a new authorization.

Parent / Guardian Name: _____

Parent / Guardian Signature: _____ Date: _____

School Acknowledgment

The designated staff members acknowledge that they have received instruction from the parent/ guardian regarding this medication and understand the procedures described.

Staff Member	Signature	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

School Administrator Approval

Administrator Name (Print): _____

Signature: _____ Date: _____

Authorization Period:
Current School Year: _____ From _____ to _____