Hartford Union High School District

2023 – 2024 School Year

Parent/Guardian Authorization Form for Administering Medication

Student Name:	**Date of Birth:**
School: Hartford Union High School	**Grade:**
Physician Name:	**Physician Phone:**

Physician signature is required for:

1) All prescription medications.
2) Any over the counter medications over the recommended dose on the container.

Medication Name	Dose	Route	Time to be given	Reason	Stop Date

Hartford Union High School District

- I hereby give permission for HUHS's trained staff to give the medication to my child according to the directions stated above. I agree to hold HUHS's, it's employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- I give permission for the school staff, including the district designated health care professionals, to contact my child's physician with any concerns regarding medication administration.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

    - Medication must be brought to school in the original packaging
    - Medication may NOT be expired
    - Students may carry and self-administer **over the counter** medication with this signed form on file and school nurse approval

Parent signature	Phone number	Date

Physician signature	Phone number	Date

By signing this form, I, the physician, am stating I have reviewed and agree with the plan of having the school administer the named medication(s) to the student specified on this form.

To be completed by the School Nurse

I am herein designating the trained school personnel to administer the medication as prescribed above to the student indicated on this form.

Students may carry and self-administer the above over the counter medication.

School nurse signature