School: _____

School Year: _____

Grade:_____Teacher: _____

Height: _____ Weight: _____

Parent-Prescriber Authorization (PPA) for Medication at School

Student Name: _____ DOB: _____ Age: _____

Allergies: _____ Start Date: _____ Stop Date: _____

Medication Name: _____ Strength (e.g. mg, mL, units): _____

☐ PRN, give as needed for: _____

Dosage Form (e.g. tablet, capsule, liquid): _____ Route: _____

Frequency (e.g. specific time or hourly intervals): _____

Additional instructions: _____

Is this medication required during bus transportation? ☐ Yes ☐ No

Is ***self-administration**** of this medication permitted? ☐ Yes ☐ No *(Self-administration means that the student can consume, inject, instill, or apply medication in the manner directed by the prescriber without additional assistance or direction).*

Licensed Healthcare Provider (Print): _____ Phone: _____

Signature: _____ Date: _____ Fax: _____

I authorize the school nurse to administer or delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the Alabama Administrative Code. I understand that additional prescriber-parent signed statements will be necessary if any part of the medication order changes. ***I understand that the medication container must match the above order for the school nurse to accept.*** I understand that over the counter (OTC) medication must be in the original, unopened, and sealed container.

Parent or Guardian Signature: _____ Date: _____ Phone: _____

***Self-Administration** Parent Authorization: I authorize and recommend self-administration of medication by my child as ordered above. I affirm that he/she has been instructed in proper self-administration, is accountable for safe and appropriate possession, and will not share medication with another person. I shall indemnify and hold harmless the school, agents of the school, and the local Board of Education against any claims that may arise relating to my child's self-administration of the prescribed medication.

Parent or Guardian Signature for ***Self-Administration***: _____ Date: _____

***Self-Administration** Student Authorization: I can identify, select, self-carry, and self-administer the medication as prescribed above. I understand the frequency and purpose of the medication and will follow safe school self-administration procedures, including not sharing medication with another person.

Student Signature for ***Self-Administration***: _____ Date: _____