For Office Use Only:

Date Received	QTY
Staff Initials	Parent Initials

Liberty Tech Charter School Health Services
SCHOOL MEDICATION AUTHORIZATION

Student Name _____ Birth Date _____ Current Grade _____

List any drug allergies/reactions _____

If medications are be given during school hours, this form must be completed in its entirety. Please note:

- ➢ The parent/guardian must provide the school with unexpired medication in the original container.
- ➢ Liberty Tech will only accept medications delivered by the **adult** Parent or Guardian.
- ➢ Medications will be given as directed on the package or as instructed by the below physician.
- ➢ It is the responsibility of the parent/guardian to notify the school of any medication changes and complete a new Authorization Form at that time.

For Parent/Guardian To Complete: (Required for all Over-The-Counter Medication)

Name of Medication: _____ To Be Taken: □ Daily □ As Needed

Dosage: _____ Frequency: _____ Medication Expiration Date: _____

Continue medications through: □ End Date: _____ OR □ Remainder of current school year

Physician's Name: _____ Phone Number: _____

Physician Authorization (Required for Prescription, Homeopathic, and Supplement Medications)

Name of Medication _____ Dosage _____ Route _____

Frequency/Dose Schedule _____ Start Date _____ End Date _____

Condition Requiring Medication _____ Side Effects _____

Special Instructions _____

Student may carry and self-administer medication due to a life threatening condition: □ Yes □ No

Physician Signature _____ Date _____

Printed Name _____ Office Phone Number _____

I, as this child's parent/guardian, hereby authorize the named Healthcare Provider to furnish to the School Health Specialist any medical information and/or copies of records pertaining to my child's medication. I understand that under the Health Insurance Portability and Accountability Act ("HIPAA"), disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be best served while in attendance at Liberty Tech Charter School. This authorization expires on the last day of the school year.

Parent/Guardian Signature _____ Date _____

Please submit completed form along with any medications to Veronica Umstattd, School Health Specialist.

ALL MEDICATION MUST BE PICKED UP BY PARENT/GUARDIAN AT THE END OF EACH SCHOOL YEAR. UNCLAIMED MEDICATION WILL BE DISPOSED OF PROPERLY.