Last Name:	Grad. Year:

Portage Central High School
Medication Authorization Form

The safety of all of our students is our top concern. **We request that, whenever possible, medication be administered outside of the school day and students are not in possession of or consume medications at school or school-related events.** We understand that this may not always be possible. In these cases, this authorization form must be completed and submitted to the school by the parent or guardian. **This form is required for any medication (prescription, non-prescription/over the counter, herbal remedy, vitamin, or nutritional supplement) that a student will use or be in possession of during school hours or at school events.** Students found in possession of or administering a medication or substance of any of the types listed above for which no authorization has been filed with the school will be subject to disciplinary action, up to expulsion, and the medication will be confiscated.

Student's Name:

Anticipated Graduation Year:

Name of medication:

Is this a prescription medication? ☐ Yes ☐ No

Dosage:

- ☐ Regularly scheduled at the following time/s:
- ☐ Only as needed for:
- ☐ Emergency use only for:

Authorization is valid:

- ☐ Until the following date:
- ☐ Until the end of the school year, unless rescinded by parent/guardian

Medication is to be kept:

- ☐ In the Main Office
- ☐ In the student's possession

Special Instructions:

Doctor's name:

Doctor's phone number:

Parent/Guardian, Student, and School Administrator must complete the back of this form for authorization to be valid.

I understand that all medication must be kept in the original container and that prescription medications must be labeled with the student's name, dosage, doctor, pharmacy, date, and special instructions.

_____ _____
Parent/Guardian Initials Student Initials

I understand that only medications that are authorized on this form may be kept in the student's possession and must be secured at all times (e.g. locked in a car or locker or kept in a pocket).

_____ _____
Parent/Guardian Initials Student Initials

I understand that self-administering medications in a method or dosage not conforming to the prescription or manufacturer's recommendation will result in disciplinary action.

_____ _____
Parent/Guardian Initials Student Initials

I understand that the school recommends that students possess no more than a week's worth of medication at any one time and that larger amounts may be confiscated by the school.

_____ _____
Parent/Guardian Initials Student Initials

I understand that it is solely the student's responsibility to remember to take any approved medications whether those medications are stored in the office or kept in the student's possession. School staff is not responsible in any way to remind students to take medication.

_____ _____
Parent/Guardian Initials Student Initials

I understand that transferring a prescription drug of any kind for any reason to any other student will result in expulsion.

_____ _____
Parent/Guardian Initials Student Initials

I am authorizing the student listed on this form to possess and/or administer the medication listed as indicated. I understand the policies and procedures associated with medications at school. I understand that failure to follow these policies and procedures and/or failure to follow the specifics of this authorization will result in disciplinary procedures up to expulsion.

_____ _____
Parent/Guardian Signature Date

Approved by Principal/Assistant Principal: Date: