



**Medication Authorization & Administration Form
2026–2027 School Year**

Please complete one form for each medication to be administered at school.

Student Information

Student Name: _____

Date of Birth: _____ **Grade:** _____

Medication Information

Medication Name: _____

Reason/Condition for Medication: _____

Dose: _____

Route:

☐ Oral ☐ Inhaled ☐ Topical ☐ Other: _____

Time(s) to be given: _____

OR

☐ **As needed (PRN)**

If as needed, describe the specific symptoms or circumstances when the medication should be given:

Minimum time between doses: _____

Maximum number of doses in a school day: _____

Start Date: _____ **End Date:** _____

Special instructions: _____

Possible side effects or reactions FPA should watch for:

Healthcare Provider Authorization

I authorize the medication listed above to be administered to this student according to the instructions provided on this form.

Healthcare Provider Name: _____

Practice: _____

Phone: _____ **Fax:** _____

Provider Signature: _____

Date: _____

Parent/Guardian Authorization

I authorize designated Focus Plus Academy personnel to administer the medication listed above according to the healthcare provider's instructions.

I understand that:

- I must provide the medication to FPA in its **original, properly labeled container and must not be expired**.
- Prescription medication must have a current pharmacy label matching the instructions on this form.
- I am responsible for providing an adequate supply of medication and replacing medication before it expires.
- I must notify FPA promptly of any change in the medication, dose, schedule, or instructions. A new authorization may be required when medication instructions change.
- Medication may not be sent to school loose, unlabeled, or in a different container.
- This form does **not** authorize a student to carry or independently administer medication. Self-carry or self-administration requires separate approval from FPA. A separate form must be completed for self-carry or self-administration (see pages 4 and 5).
- Emergency or rescue medications may require an additional emergency action plan or other medical documentation.

Parent/Guardian Name: _____

Signature: _____ **Date:** _____

Handwritten Signature Required

Phone: _____

Student Self-Carry / Self-Administration

Complete this section only if the student will carry and/or independently administer this medication during the school day or at school-sponsored activities.

Requested authorization:

- ☐ Student may self-administer this medication.
- ☐ Student may carry this medication and self-administer it when needed.

Healthcare Provider Authorization

I confirm that this student:

- ☐ Has been instructed in the proper use of this medication.
- ☐ Understands when and how the medication should be used.
- ☐ Has demonstrated the ability to safely and appropriately self-administer the medication.
- ☐ Is medically appropriate to carry the medication, if self-carry is requested.

Additional instructions or precautions:

Is an emergency action or treatment plan required?

- ☐ No
- ☐ Yes — plan attached

Healthcare Provider Name: _____

Provider Signature: _____

Date: _____

Parent/Guardian Authorization

I request and authorize my student to self-administer and, when approved, carry the medication identified on this form.

I understand that my student is expected to use the medication only as prescribed and to notify FPA staff when assistance or emergency care is needed.

Parent/Guardian Name: _____

Signature: _____ Date: _____

Handwritten Signature Required

For Focus Plus Academy Use

Medication received by: _____

Date received: _____

Medication/container checked against authorization: ☐ Yes

Expiration Date: _____

Storage Location: _____

☐ Refrigeration required

☐ Emergency/rescue medication

☐ Additional health or emergency action plan on file

Medication returned to parent/guardian:

Date: _____ Staff Initials: _____

Medication discarded according to school procedure:

Date: _____ Staff Initials: _____