Alternative Paths Training School

Form AMAS - Authorization For Medications Administered At School

Parent/Guardian Section

Student_____**DOB**_____**Age**____**Grade**____

Parent/Guardian Signature_____ **Date**_____

Parent/Guardian Printed Name_____

Signature gives permission for APTS Nurse/Med Aide/Designee to administer prescribed medication and gives APTS Nurse/Med Aide/Designee permission to contact the physician/dentist if necessary. For Over-the-Counter medication, parent's signature gives APTS Nurse/Med Aide/Designee permission to administer medication.

Physician/Dentist Section

(*Must be completed by Physician/Dentist*)

PRESCRIPTION MEDICATION (Only one medication per form)

Name of Medication:_____

Reason medication is needed, unless confidential:_____

Dosage:_____**Length of Time:**_____

Time of day to be given:_____

If potentially serious effects exist, please outline any necessary emergency response on a separate sheet.

Physician/Dentist Signature_____**Date**_____

Physician/Dentist PRINTED Name_____

Physician/Dentist Phone_____**Fax**_____

Physician/Dentist Address_____

Over-the-Counter Medications

Name of Medication:_____

Dosage/Length of Time:_____

Time of Day to be Given:_____

Side Effects:_____

Received by:_____**Date:**_____

DISTRIBUTION: Original to be kept with medication. Copy to Student Health Record. Copy to Physician