

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

This Portion to be Completed by Health Care Provider/ Dentist

<u>Name of Medication</u>	<u>Strength</u>	<u>Dosage</u>	<u>Method of Administration</u>	<u>Time of Day To Be Given</u>
_____	_____	_____	_____	_____

Diagnosis _____

If given PRN, specify the length of time between doses _____

Indicate if student will self carry inhaler/epipen on his/her person Yes No

Anticipated action _____

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated. Medication orders are good for the current school year only, unless a shorter period is specified. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. **Medication may be administered by non licensed school personnel.**

Health Care Provider/ Dentist Signature

Date of Signature

Printed Name

Phone Number

This Portion of the Form Is To Be Completed By Parent/ Guardian

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with the health provider's prescribed instructions, not to exceed the current school year.

Medication must be supplied to the school in the original container

Parent/ Guardian's Signature

Date of Signature

Phone Number: Home/Work (indicate area code)

WHITE: Keep with medication (school copy)

YELLOW: Nurse