MEDICATION/TREATMENT AUTHORIZATION FORM

Student's Name_____ Sex_____

Date of Birth_____ Grade_____ School Name_____

The following section is to be completed by the parent or legal guardian:

I hereby grant permission to the principal or his/her designee of _____School to assist in the self-administration of the prescribed or over-the-counter medication and/or treatment to my child while in school and away from school while participating in official school activities. **It is my responsibility to notify the school if and when these orders change.**

Parent/Guardian name: _____ Relationship:_____

Emergency Phone #: _____ Home Phone #: _____ Business Phone #:_____

Address: _____

Signature: _____ Date:_____

Over the Counter Medication Authorized:_____

Instructions to Assist with the Self-Administration by the Student of the Medication:

_____

List child's allergies: _____

The following section is to be completed by the prescribing physician for prescription medication:

(A separate form must be completed for each medication or treatment prescribed)

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment, which is necessary to be given in school. I am aware that trained non-medical staff may administer this physician prescribed service.

This order is to be effective for the school year: 201____ - 201____ or earlier stop date: _____
Diagnosis *(for this medication/treatment)*:
Treatment:

Name of Medication: Brand: _____ Generic: _____ **Strength** *(i.e. mg/tab)*: _____

Instructions to Assist in the Self-Administration of the Medication by the Student:

Amount *(i.e.# of tablets or teaspoons)*: _____ **Time** *(s)*: _____

Frequency *(i.e: q 6 hrs prn)*: _____ **Duration** *(i.e: 10 days)*: _____

Route: Oral ___ Topical ____ Subcutaneous ____ I.M. ____ Inhaled____ Other *(describe)*: _____

Time medication is given at home *(if applicable)*: _____

Possible side effects: _____

Is student authorized to carry and use asthma inhalation medication or EpiPen? _____

(The Authorization for Possession or Self-Administration of Asthma, Severe Allergy, or Anaphylaxis Medication must be completed entirely by the parents and the physician for a student to be allowed to possess and/or self-administer asthma or severe allergy medication or an Epi-Pen.)

Has student been instructed in the use of asthma inhaler or EpiPen? Yes No

Other Information:

Physician Signature: _____ Date: _____

Physician Name: _____

Office Address: _____ Phone: _____ Fax: _____