TIVERTON SCHOOL DEPARTMENT
MEDICATION ADMINISTRATION

PHYSICIAN AUTHORIZATION

FOR EPIPEN ORDERS USE REVERSE FORM

Student Name _____ DOB _____

Name of Medication _____ Daily _____ PRN _____

Dosage while in school _____ Route of Administration _____ Time to be Given _____

Diagnosis _____

Is this a new medication _____ Expected Duration _____

List significant side effects _____

Self-carry/self-administer in the school setting:
Please circle the appropriate response below.(DOES NOT APPLY TO CONTROLLED SUBSTANCES)

- Do you authorize this child to self-carry the above ordered medication in the school setting? (Excludes elementary grade students). YES NO
- Do you authorize this child to self-administer the above medication in the school setting? YES NO

Field trip information:

- On an off-site school-sponsored activity without a nurse present, this student may self-carry the above medication? (Excludes elementary grade students) YES NO
- On an off-site school-sponsored activity without a nurse present, this student may self-administer the above ordered medication? YES NO
- The above medication may be omitted. YES NO

Print Physician Name _____

Physician Signature _____

Address _____ **Date** _____

****

PARENT/GUARDIAN AUTHORIZATION

I authorize the above medication be administered to my child under the direction of my health care provider. The school nurse may contact my health care provider regarding this medication if necessary.

- My child may self-carry the prescribed medication. (Excludes elementary grade students). YES NO
- My child may self-administer the prescribed medication. YES NO

Signature of Parent/Guardian _____ **Date** _____