Prosser Consolidated School District No. 116
Health Services

AUTHORIZATION FOR ADMINISTRATION OF EMERGENCY MEDICATION

Student Name: _____ DOB: _____

School: _____ Teacher: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER

Name of Medication _____ Dosage _____ Method/Location of Administration: SQ.IM _____

Reason for medication to be given during school hours (please describe symptoms, and when to administer medication, time lapse from allergen exposure, etc.): _____

Anticipated Action, Recommended Follow-Up: _____

Possible Side Effects of Medication: _____

Emergency Procedure in Case of Serious Side Effects: _____

Can this student carry and administer this medication at school? ____ Yes ____ No

Please Note! If student does NOT carry his own medication, one dose is kept in the nurse's room. It is sent on field trips when appropriateIf available give 2nd Epi-Pen if 9-1-1 hasn't arrived in 20 min.**

Does this child need more than one dose at school? _____ *How many?* _____

Where should this medication be kept at school? Classroom _____ *School Bus* _____ *Other* _____

Can this student travel on field trips more than 30 minutes away from a medical facility? _____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above from: _____ to _____ (not to exceed the current school year) as there exists a valid health reason which makes the administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by unlicensed school personnel under the delegation and supervision of a registered nurse.

_____ Signed: _____

Date of Signature Physician (MD, DO)/Dentist (DDS)/ARNP/PA

_____ _____

Phone Number Printed Name

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request and authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from: _____ to _____ (not to exceed the current school year). I understand that this medication may be given by an unlicensed school person in the absence of the nurse. I understand that the school encourages parents of students with medical problems/severe allergies to attend field trips with their child.

My child is capable of self-administration of this medication: Yes / No

Signature: _____ Date: _____

Phone: (Work) _____ Phone: (Home) _____

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FIELD TRIP MEDICATION

Student: _____ Age: _____

School: _____ Grade: ____ Teacher: _____

Medication: _____ Dosage: _____

Time to be Given: _____ Date: _____

_____ _____
Signature of Person Giving Medication Date

Date and Time Medication **WAS GIVEN**: _____
(Date) (Time) (Initial)

Please return this paper to the Health Room after the field trip. The nurse will transfer the information to the Student Medication Log and verify any medication returned to the Health Room. Thank you.