

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

Please print legible instructions

<u>Name of Medication</u>	<u>Dosage</u>	<u>Method of Administration</u>	<u>Time(s) to Be Taken</u>	<u>Take With Food</u>
_____	_____	_____	_____	_____ Yes _____ No

Diagnosis or reason for medication: _____

If given "As needed", specify the minimum length of time between doses: _____

I request and authorize this student to carry their medication: _____ Yes _____ No

I request and authorize this student to self-administer their medication: _____ Yes _____ No

This student has been instructed and has demonstrated the ability to properly manage self-administration of medication:

_____ Yes _____ No Possible Medication Side Effects: _____

Emergency procedure in case of serious side effect symptoms:

I request and authorize the above-named student be administered the above identified medication in accordance with
The instructions indicated above from _____ (date) to _____ (date) (not to exceed current
school year).

Date of Signature

Signature of Licensed Health Professional (LHP)

Telephone Number

Please Print name of LHP

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request that this medication is to be given as ordered by the licensed health professional
- I give Health Services Staff permission to communicate with the medical office about this medication. I understand that oral, nasal, eye, ear and topical medications may be administered by non-licensed staff members who have been trained yearly and are supervised routinely by a Registered Nurse
- Medication information may be shared with school staff working with my child and 911 staff, if they are called
- All medication supplied must be brought to school by a parent/guardian in its original container with a Pharmacy-generated script and instructions as noted above by the licensed health professional

I request and authorize my child to carry and/or self-administer their medication _____ Yes _____ No

Date of Signature

Parent/Guardian Signature

Home Number: _____ (work) _____ (cell) _____

Reviewed by Registered Nurse: _____ Date: _____