Clearfield School District Health Center
2831 Washington Ave/PO Box 910/Clearfield, PA 16830
(814) 765-5511/ Fax (814) 765-2405

# MEDICATION ADMINISTRATION AUTHORIZATION AT SCHOOL

Student's name: _____ Birthdate: _____

School: _____ Grade: _____

**This section to be completed by Health Care Provider**

Medication: _____ Strength: _____

Dose: _____ Route: _____

Time to be given: _____ If PRN, length of time between doses: _____

**If approved by school, can student self-carry and self-administer medication?** Yes:☐ No: ☐

Anticipated action of medication: _____

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

Diagnosis: _____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated. 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.

_____ _____

Health care Provider Signature Date

_____ (____)_____

Printed Name Phone Number

**This section to be completed by Parent/Guardian**

As the parent/guardian, I authorize the school to administer the medication to my student in accordance with the health care provider's instructions. This order is valid only for the current school year, which includes summer school.
**Medication must be supplied to the school in the original container.**

_____ _____

Signature of Parent/Guardian Date

_____ (____)_____

Printed Name Phone Number