SCHOOL TOWN OF HIGHLAND
HEALTH SERVICES

AUTHORIZATION TO ADMINISTER MEDICATION DURING SCHOOL HOURS
(To be placed in student's file after signing)

PHYSICIAN'S STATEMENT (required for prescription medications)

I have prescribed the medication indicated below for:

_____, and do hereby authorize the nurse,
student's name

principal, or their designee, of the school to administer the medication as indicated:

Diagnosis: _____

Medication: _____

Student may hand carry AND self-administer this medication: Yes_____ No_____
(must be life-threatening condition, such as asthma)

Dosage and time to be given: _____

Date: _____ _____M.D.
Physician's signature

PARENTAL AUTHORIZATION

I wish _____ to receive:
student's name

_____ at _____
name of medication and dosage time to be given

I agree that student may hand carry AND self-administer this medication: Yes___ No___
(must be life-threatening condition, such as asthma)

Date: _____ _____
parent signature

PLEASE NOTE: The physician's statement and the parental authorization are valid only for the current school year. Unless the authorization and statement are renewed, the medication cannot be given to the student. Refer to the Parent Handbook for the complete policy.
12/02 da