



## DAVIS SCHOOL DISTRICT Authorization of School Personnel to Administer Medications

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Parent / Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 School / Teacher: \_\_\_\_\_

Name of licensed health care provider completing form: ***(Please Print)***

\_\_\_\_\_

***Licensed Health Care Provider's Statement:***

1. Name / type of medication: \_\_\_\_\_
2. Dosage / amount to be given: \_\_\_\_\_
3. Frequency / time(s) to be administered: \_\_\_\_\_
4. Duration (week, month, indefinite, etc.): \_\_\_\_\_
5. Anticipated reactions to medication (symptoms, side effects for underdose, overdose etc.):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. If PRN for mental health issues or needs, describe physical symptoms requiring administration:  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
Signature of Licensed Health Care Provider

\_\_\_\_\_  
Date

**Parent / Guardian Request / Approval**

I hereby request and give my permission for the above named student to receive the specified medication as stated in the above instruction from the health care provider. I understand that the school administration will designate specific staff to administer medication, train staff, assure proper identification and safekeeping of medication, and maintain records of such administration of medication.

I further understand that school personnel who provide assistance (administration of specified medication so noted) or employer of such staff are not liable, civilly or criminally for any adverse reaction suffered by my child as a result of taking the medication so indicated and discontinuing the administration of the medication in keeping with the procedure outlined above.

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date