Davis School District
Health and Nursing Services

20 North Main • Farmington, UT 84025
Office (801) 402-5540, FAX 402-5341

Authorization of School Personnel to Administer Medications

Name of Student: _____ DOB: _____

Parent / Guardian: _____ Phone: _____

School/Grade: _____

Licensed Health Care Provider's Statement:

1. Name / type of medication: _____
2. Given for / Diagnosis: _____
3. Dosage / amount to be given: _____
4. Route (by mouth, injection, etc.): _____
5. Frequency / time(s) to be administered: _____
6. Duration (week, month, indefinite, etc.): _____
7. Anticipated reactions to medication (side effects):
   _____
8. If PRN, describe symptoms requiring administration: _____
   _____

Licensed Health Provider Signature: _____ Date: _____

Printed Name: _____

Parent/Guardian 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.

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____