Albany Area Schools

Authorization for Administration of Medication

2019-20

Student_____DOB_____School_____Gr____

Parents/Guardian must provide school staff with:

1. Physician order for medication
2. Parent/Guardian written permission
3. Medication supplied in a pharmacy labeled bottle (even for OTC meds)

Physician Order (Medical Provider completes this section)

Medication name_____Time given_____

Dose, frequency, route_____

For treatment of_____Last date to be given_____

Possible side effects_____

Special instructions_____

If an inhaler, may student carry it & self-administer __Yes __No

Provider signature_____Date_____

Clinic phone_____Clinic fax_____

Parent/Guardian Permission

I request this medication be given as prescribed. I understand I must provide the medication in the original pharmacy labeled bottle. If the medical order for medication or dose changes, I will inform the school nurse by the next school day. I authorize the school nurse to communicate with the health care provider for the purpose of administering and monitoring effects of this medication at school.

_____ _____

Guardian/Parent signature Date

_____ _____

RN signature Date