Davis School District
Health and Nursing Services

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

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. 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 (symptoms, side effects for under dose, overdose etc.):

   _____

   _____
8. 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