Authorization for Administration of Medication at School

(Writable PDF)

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

This Portion to Be Completed By the Licensed Health Professional

Name of Medication	Dosage	Method of Administration	Time(s) to Be Taken

Diagnosis or reason for medication: _____

If given PRN, specify the minimum length of time between doses and when to administer: _____

May the student carry this medication on his/her person and self-administer? ☐ Yes* ☐ No

* Student has demonstrated to licensed health professional the ability to correctly administer this medication. Student under 12 years may be permitted to carry and self- administer a metered dose inhaler and/or emergency medication for a predetermined, life-endangering situation (Monroe School Diastrict Board Policy 5432).

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above from _____ (date) to _____ (date) (not to exceed current school year). There exists a valid health reason which may make administration of the medication advisable during school hours.

_____ _____

Licensed Health Professional Signature Date

_____ _____ _____

Name (please print) Phone Fax

This Portion to Be Completed By the Parent/Guardian

- I request this medication be given as ordered by the licensed health professional.
- I give Health Services Staff permission to communicate with the medical office about this medication. I understand oral medications may be administered by non-licensed staff members who have been trained and are supervised by a Registered Nurse.
- Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must be brought to school in its original container with instructions as noted above by the licensed health professional.

I request and authorize my child to carry and/or self-administer his/her medication. ☐ Yes ☐ No

_____ _____

Parent/Guardian Signature Date

Telephone #: Home:_____ Work:_____ Cell: _____

Reviewed by Registered Nurse: _____ Date: _____

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060509
www

This authorization is valid for the current school year only