Authorization for Administration of Medication at School

Parents/guardians asking school staff to give medications (including over the counter medications) to their child must provide (written) permission every school year that has been signed by **parent/guardian AND the child's Physician/Licensed Health Care Provider**.

Physician Authorization

Student: ______________________ BD: __________ Grade______________

School: ______________________ School Year: ________ Teacher______________

Physician/licensed prescriber's orders for administration of Medication by School Personnel

Medical Condition	Medication	Dose	Time	Route	Possible Side Effects
1.					
2.					
( ) Please check if Tylenol to be given for Headache, Fever or Pain-Inflammation	Tylenol	Wt. (by RN's Scale)	As Needed	Oral	

Other considerations/directions: ____

Medication **ALLERGIES:** ____

Start Date: ______________________ Stop Date: ______________________

(All Authorizations expire at the end of the school year or following the summer school session)

SIGNATURE *of Physician/Licensed Prescriber* **PRINT** *name of Physician/Licensed Prescriber* *Date*

Clinic Address *Phone* *Fax*

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by my child's Physician/Licensed Prescriber.
2. **All medications sent to school will be in an appropriately labeled pharmacy container or an original labeled container.**
3. I also request that the medication(s) be given on field trips; as prescribed, by a teacher or other responsible adult.
4. I will notify the school of any change in the medication(s), (i.e. dosage change, medication is stopped, etc.).
5. I give permission for the medication(s) to be given by school personnel as delegated, trained and supervised by the school nurse.
6. I give permission for the school nurse to communicate, as needed, with the school staff about my child's medical condition(s) and the action of the medication(s).
7. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by medication(s).
8. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.
9. Legally, you may refuse to sign for the medication. If you refuse to sign, we will not be able to administer the medication at school.
10. This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

[ ] Yes [ ] No If this authorization is for Acetaminophen (Tylenol), I give permission for my child to take this medication from the school's supply. (If no is checked, parents/guardians will need to supply the medication in an original container.)

Parent/Guardian Signature **Date** **Relationship to student**

Return to: ______________________ **Phone:** __________ **Fax:** __________

Licensed School Nurse