DAVIS SCHOOL DISTRICT
SCHOOL MEDICATION AUTHORIZATION FORM

Health & Nursing Services
20 North Main, Farmington, Utah 84025
Office (801) 402-5540
Fax (801) 402-5341

STUDENT INFORMATION

Student:	School:	DOB: Grade:
Parent:	Phone:	Email:

Parent: complete the above section, read and sign below, obtain signature from Health Care Provider and return to school.

As parent/guardian I request the medication(s) listed below be given to my student during regular school hours.
☐ I understand medication will be administered by trained school employee volunteers.
☐ I understand a new medication authorization form will be required annually, and whenever there is a dosage change.
☐ I understand parent or guardian is responsible for maintaining necessary supplies, medications, and equipment.
☐ I understand prescription medication must be transported to and from school by an adult*.
☐ I understand all prescription medication must be in a current original pharmacy container and label, with the child's name, medication name, administration time, dosage, and health care provider's name.
☐ I understand over-the-counter medication must be in the original manufacturer's container and labeled with the child's name, administration time, dosage.
☐ I understand the information contained in this order will be shared with school staff on a need-to-know basis.
☐ I understand it is my responsibility to notify the school nurse of any change in my student's health status, care or medication order.

I give permission for my child's healthcare provider to share information with the school nurse for the completion of this order and I agree to above statements.

Parent Signature:_____Date:_____

MEDICATION INFORMATION

If a request is being made for school staff to administer asthma medication, epinephrine auto-injector, diabetes medication, or seizure rescue medication, an additional specific form(s) will be required, and must be signed by the parent and physician, and kept on file at the school. These supplemental forms will also be required for students who carry and self-administer asthma medication, epinephrine auto-injectors, and diabetes medications. Seizure rescue medication cannot be carried by a student.

Name of Medication	Indication/Diagnosis	Dosage	Route	Time	Side Effects	# received by school

If PRN, describe symptoms requiring administration:

Medication will be kept: ☐ In the office ☐ Student carries* ☐ Other:

SIGNATURE: This form must be signed by prescriber to be valid and can only be signed by an MD/DO; Nurse Practitioner, Certified Physician's Assistant or a provider with prescriptive practice.

The above-named student is under my care. It is medically necessary for medication administration while student is under the control of the school.
☐ **It is** medically appropriate for the student to self-carry* this medication, when able and appropriate, and be in possession of this medication and supplies at all times (see statement above under Medication Information). This student has been trained to self-administer the medication and is capable of doing this safely.
☐ **It is not** medically appropriate to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain this student's medication for use if needed.

Prescriber Signature: _____ Date: _____

Print Prescriber Name: _____ Phone _____ Fax: _____

School Nurse: _____ Signature: _____ Date: _____

Person receiving meds: _____ Signature: _____ Date: _____

*Student may carry some medication in certain circumstances. This applies to asthma medication, epinephrine auto-injectors, and diabetes medications, and ONLY after supplemental forms are completed and turned in to the school.