SCHOOL MEDICATION AUTHORIZATION FORM

School Year:

A new form for each school year and for any change in the medication, dose or frequency.

Name_____Birthdate_____Homeroom_____

I have read the Medication in School Policy and give permission for my child to receive the medication(s) prescribed by my doctor during school hours. I understand that I must promptly notify the school district of any changes in the medication, dosage or frequency and provide refills of the medication as needed.

_____ _____

Parent/Guardian Signature Date

My child **WILL /WILL NOT** be self administering their **Epi-Pen/Asthma** medications.

_____ _____

Parent/Guardian Signature Date

----------TO BE COMPLETED BY THE PHYSICIAN----------

Dear Doctor,

Please provide the following information below along with any special precautions or indications for the above child receiving the medication during school hours.

Medication name, dosage and frequency:_____

Purpose of the medication:_____

Potential side effects:_____

Other prescriptions or OTC medications used by this student:_____

WIll this medication need to be taken with the student on any field trips:_____

Student Allergies:_____

Please provide any additional information regarding emergency care, specific safety information, signs and symptoms of potential adverse reactions:_____

_____

_____

Physician Signature/Printed Name Telephone Number Date

AUTORIZACIÓN PARA ADMINISTRAR MEDICAMENTOS EN LA ESCUELA

Cada año escolar se necesita llenar una nueva forma, también cuando existen cambios en la dosis o frecuencia del uso se estos medicamentos

Nombre _____ Fecha de nacimiento _____ Salon _____

He leido la politica (reglamento) sobre el uso de **Medicamentos en la Escuela** y doy permiso para que durante las horas escolares, se le de a mi hijo(a) se de la medicina que ha recetado mi doctor. Estoy enterado que dar aviso inmediato en caso de que hubiera cualquier cambio en los medicamentos, las dosis o la frecuencia en que se tenga que dar, así como que tengo que suministrar las medicinas a medida que se vayan terminando.

_____ _____

Firma del Padre o Tutor Fecha

Mi hijo(a) **PUEDE/NO PUEDE ADMINISTRARSE** la medicina **EPI-PEN** o la medicina para el **ASMA** por sí solo.

_____ _____

Firma del Padre o Tutor Fecha

----------TO BE COMPLETED BY THE PHYSICIAN----------

Dear Doctor,

Please provide the following information below along with any special precautions or indications for the above child receiving the medication during school hours.

Medication name, dosage and frequency:_____

Purpose of the medication:_____

Potential side effects:_____

Other prescriptions or OTC medications used by this student:_____

WIll this medication need to be taken with the student on any field trips:_____

Student Allergies:_____

Please provide any additional information regarding emergency care, specific safety information, signs and symptoms of potential adverse reactions:_____

_____

_____ _____ _____

Physician Signature/Printed Name Telephone Number Date