

**Licensed Authorized Prescribing Practitioner Authorization to Administer Medication in School Reference Policy # 2240**

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Medication \_\_\_\_\_

Dosage \_\_\_\_\_

To be given at the following time (s) \_\_\_\_\_

\_\_\_\_\_

Special Instructions \_\_\_\_\_

\_\_\_\_\_

May Self Carry (Epi-Pens and Inhalers only)

Purpose of Medication \_\_\_\_\_

\_\_\_\_\_

Side Effects that need to be reported \_\_\_\_\_

\_\_\_\_\_

Starting Date \_\_\_\_\_

Ending Date \_\_\_\_\_

\_\_\_\_\_  
*Signature of Licensed Authorized Prescribing Practitioner*

\_\_\_\_\_  
*Printed Name of Licensed Authorized Prescribing Practitioner*

Phone Number \_\_\_\_\_ Date \_\_\_\_\_

If a child has a condition that might require medication on an emergency basis (e.g., in the case of a child's allergic reaction, asthma attack, etc.), the child's parent or legal guardian must provide all necessary information and training or instruction to the designated staff members who might be responsible for administering such medication or carrying out such medical procedures.

For Inhalers & EpiPens only: Doctor, please sign below to give permission for student to carry and self-administer the Inhaler and/or EpiPen ordered on this form.

\_\_\_\_\_ Date \_\_\_\_\_

*Physicians Signature*