



**Provider and Parent/Guardian Permission to Administer Medication at  
School/School Sponsored Events (Grades 6-12)**

To be completed by the Parent/Guardian

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher/HR: \_\_\_\_\_ School: \_\_\_\_\_

I request the school nurse give medication listed on this plan; or after the nurse determines my child is self-directed, trained staff may assist my child (in the absence of the nurse) to take their own medication. I will provide the medication in the original pharmacy or over the counter container, with a proper expiration date. Medication and refills must be brought to school by an adult.

This plan will be shared with school staff caring for my child.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Email

\_\_\_\_\_  
Phone where we can reach you

**To Be Completed by Health Care Provider-Valid for the Current School Year**

Diagnosis \_\_\_\_\_

ICD 10 Code \_\_\_\_\_

MEDICATION	DOSAGE	FREQUENCY/TIME/DURATION TO BE TAKEN	ROUTE OF ADMINISTRATION

**Note:** Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

- I attest that this student has demonstrated to me that they can self-administer the medication(s)
- Inhaler,  Epi Pen,  insulin/glucagon/diabetic supplies safely and effectively, and may carry and use this medication independently at school/for school sponsored events.

\_\_\_\_\_  
Name/Title of Prescriber (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Phone

License # \_\_\_\_\_

NPI # \_\_\_\_\_

\_\_\_\_\_  
*Prescriber's address*

Dismissal on half days:

- Yes, please give my child his/her medication on half days.
- No, please do not give my child his/her medication on half days.