PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child _____DOB_____receive the medication as prescribed below by our physician. The medication is to be furnished by me in the original container from the pharmacy*.

PLEASE CHECK ONE:

☐ I understand that the school nurse or other designated person in the absence of the school nurse, will administer the medication, including field trips to my **self-directed child.**

☐ I understand that administration of oral, topical or inhalant medications to my **non self-directed child** and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

☐ May self administer medication (please indicate what medication)_____.

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of student: _____DOB_____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible side effects and adverse reactions (if any):_____

Physician's Signature:_____Date:_____

Address: _____Phone:_____

* Medication must be in original pharmacy labeled container with specific orders and name of medication.* Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent(s)/guardian(s):

Parent Signature:_____Date:_____