AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY
(Please clearly print legible instructions)

Name of Medication	Dosage	Method of Administration	Time(s) to Be Taken

Diagnosis or reason for medication: _____

If given PRN, specify the minimum length of time between doses: _____

I request and authorize this student to carry their medication. _____Yes _____ No

I request and authorize this student to self-administer their medication. _____Yes _____ No

This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

Possible medication side effects: _____

Emergency procedure in case of serious side effects: _____

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above from _____ (date) to _____ (date) **(not to exceed current school year)**. There exists a valid health reason which may make administration of the medication advisable during school hours.

_____ _____
Date of Signature Licensed Health Professional (LHP)

_____ _____
Telephone Number Name **(please print)**

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request this medication to be given as ordered by the licensed health professional.
- I give Health Services Staff permission to communicate with the medical office about this medication. I understand oral medications may be administered by nonlicensed staff members who have been trained and are supervised by a Registered Nurse.
- Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must be brought to school in its original container with instructions as noted above by the licensed health professional.

I request and authorize my child to carry and/or self-administer their medication. _____ Yes _____ No

_____ _____
Date of Signature Parent/Guardian Signature

Telephone Numbers: _____(home) _____ (work) _____(cell)

Reviewed by Registered Nurse: _____ Date: _____