

**AUTHORIZATION FOR MEDICATION ADMINISTRATION IN EMERGENCY/DISASTER ONLY**

THIS AUTHORIZATION IS TO BE USED ONLY IN CASE OF EXTREME EMERGENCY/DISASTER  
AND THE PUPIL IS REQUIRED TO REMAIN AT THE SCHOOL BEYOND NORMAL SCHOOL HOURS  
FOR SAFETY OR UNTIL THE PARENT/GUARDIAN CAN PICK THEM UP.

In the event of an emergency, the school nurse or other designated school district personnel is to give the following medication(s) to: \_\_\_\_\_ at the times and in the amounts listed below:  
student's name birth date

<u>Medication</u>	<u>Dosage</u>	<u>Amount</u>	<u>Expiration Date</u>

I, \_\_\_\_\_, the parent/guardian have provided **72 hours worth of medication to be kept locked at the school for emergency use**. Each type of medication is in its original container, labeled with the student's name, dosage, amount to give, what times to give and any expiration date for medication.

I realize that it is my responsibility to provide the school with an updated authorization form and change in medication(s) any time the doctor changes the student's medication.

I request designated school personnel to administer the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, the parent/guardian must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the health care providers allowed by HIPAA.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

The above-named child is on the medication listed. The dosage, amounts given, and time given are as stated above.

**Physician Signature** \_\_\_\_\_ **NPI #** \_\_\_\_\_ **Date** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

