Authorization for Administration of Medication At School

Student's Name _____ Birth Date _____

School _____ Grade _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL

Name of Medication	Dosage	Methods of Administration	Time of Day to be Taken

If PRN specify the length of time between doses: _____

Diagnosis or health reason for medication: _____

Permission to carry: Inhaler YES ☐ NO ☐

Epi-Pen YES ☐ NO ☐

Insulin YES ☐ NO ☐ (Insulin injection may not be delegated to unlicensed staff)

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above from _____ to _____(not to exceed current school year). There exists a valid health reason, which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Trained school personnel may administer such medication.

Date of Signature _____ Licensed Health Professional's Signature _____

Telephone Number _____ Name (Please Print or Type) _____

FAX Number _____ Address _____ City _____ Zip Code _____

THIS PORTION TO BE COMPLETED AND SIGNED BY THE PARENT / GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or instructions from a licensed health professional.

MEDICATION MUST BE SUPPLIED TO THE SCHOOL IN THE ORIGINAL CONTAINER.
WRITTEN AUTHORIZATION MUST MATCH EXACTLY THE INFORMATION ON THE CONTAINER.

I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed. Permission granted to exchange medication information with the nurse.

Date of Signature _____ Parent / Guardian's Signature _____ Home Phone _____ / Work Phone _____

Reviewed by _____, **School Nurse** **Date** _____