

## Medication and Treatment Authorization Form

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Allergies: \_\_\_\_\_

**All medications and treatments require a medical order.**

**All medications must be supplied in the original packaging or prescription container.**

| Medication Requested During School Hours |             |            |      |      |       |                       |
|------------------------------------------|-------------|------------|------|------|-------|-----------------------|
| Medical Condition                        | ICD 10 Code | Medication | Dose | Time | Route | Possible Side Effects |
| 1.                                       |             |            |      |      |       |                       |
| 2.                                       |             |            |      |      |       |                       |
| 3.                                       |             |            |      |      |       |                       |

| Treatments/Procedures Required During School Hours<br>(e.g., blood glucose monitoring, catheterization, suctioning, ostomy, dressing changes) |             |                     |                   |                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------|---------------------|-------------------|----------------------|
| Medical Condition                                                                                                                             | ICD 10 Code | Treatment/Procedure | Time(s)/Frequency | Special Instructions |
| 1.                                                                                                                                            |             |                     |                   |                      |
| 2.                                                                                                                                            |             |                     |                   |                      |

☐ *Student may carry/self-administer his/her inhaler.*

This student uses inhaled medication, and has been instructed on proper use, side effects and safeguards regarding the medication. The student is authorized to keep this medication with them during the school day and to use as needed according to licensed prescriber's instructions. Prior to self-carry, the school nurse will verify proper use of the inhaler.

☐ *Student may carry/self-administer his/her Epi-Pen injector.*

This student uses an Epi-Pen, and has been instructed on proper use, side effects and safeguards regarding the medication. The student is authorized to keep this medication with them during the school day and to use as needed. Prior to self-carry, the school nurse will verify proper use of the injector.

Physician signature \_\_\_\_\_

Print name of physician \_\_\_\_\_

Date \_\_\_\_\_

Clinic Address \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

### Parent/Guardian Authorization

1. I request that the above medication(s)/treatment(s) be given during school hours.
2. I will provide the required documentation from a licensed prescriber following the district medication policy and procedures.
3. All medication administered must be approved by the F.D.A. Herbal dietary supplements are encouraged to be administered at home. CBD and or THC products are prohibited on school grounds. A licensed school nurse will handle all other requests individually.
4. I give my permission for the medication(s)/treatment(s) to be given by school personnel as delegated, trained and supervised by a Licensed School Nurse. I understand that a nurse may not necessarily give medication(s) or treatments.
5. I will notify the school of any change in the medication(s)/treatment(s).
6. This consent may be revoked at any time by giving written or verbal notice to the school health office. Without revocation, authorization expires at the end of each school year or after the summer program concludes.
8. I give permission for the Licensed School Nurse to consult with my child's physician about any questions regarding the listed medication(s)/treatment(s) or medical condition(s) being treated.
9. I understand that the school intends to use the requested information to provide for my child's health and safety needs while at school. I may refuse to supply the requested personal information. The consequence for not providing the information may result in that my child will not be able to take medication(s)/receive treatment(s) during school hours dispensed from the health office. The information I provide will be shared only with staff in the school whose jobs require access to this information to ensure your child's safety and school success.
10. I understand that the school utilizes a physician approved "Standing Order Set" and follows the American Heart Association CPR and Emergency First Aid protocols that will be applied to my student while onsite or participating in a school-led activity.

Parent/guardian signature \_\_\_\_\_

Relationship to student \_\_\_\_\_

Date \_\_\_\_\_

Health Office staff signature \_\_\_\_\_

Date \_\_\_\_\_

School Year \_\_\_\_\_