AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To Be Completed By Parent or Guardian:

I request that my child ________________________________ grade ______________ receive medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.

Signature (Parent or Guardian) __________________________ Date: ______________

B. To Be Completed By The Licensed Health Care Provider:

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

Name of Student: __________________________ Date of Birth: ______________

Diagnosis: ____________________________________________________________

Name of Medication: ________________________________________________

Prescribed Dosage, Frequency, and Route of Administration: ______________

Time to be taken during school hours: _________________________________

Duration of Medication Order: ________________________________

Possible Side Effects and Adverse Reactions (if any): ______________________

Other Recommendations: _____________________________________________

Name of Licensed Prescriber and Title (please print): _____________________

Prescriber’s Signature: __________________________ Date: ______________

Address: __________________________________ Phone: ______________

Under certain conditions it may be necessary for a student to carry and self-administer his or her own medication. The decision to allow a student to do this will be made on an individual basis, according to the severity of the health condition, with parental request, a physician’s order, and an assessment by the school nurse of the student’s ability to carry and administer his/her medication properly. The self-medication release form must be completed.