

Medication Authorization
For Oral and Emergency Injected Medication Administration at School

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

Student's Healthcare Provider to complete this section

Doctor/Healthcare provider please complete this section using one form for each medication

Diagnosis or reason for medication: _____

Severity of the problem: ☐ mild ☐ moderate ☐ severe

Activity modifications or restrictions: _____

Name of Medication	Dosage	Method of administration	Time to be given or frequency if PRN

If given PRN, describe indications: _____

Possible side effects of medication: _____

For EpiPens, describe signs or symptoms when to use: _____

Can the student travel on field trips > 30 minutes away from emergency medical response? ☐ yes ☐ no

Student has been instructed in the correct way to use this medication. ☐ yes ☐ no

Student has demonstrated the skill level necessary to use the medication appropriately without supervision. ☐ yes ☐ no

Student may carry and self-administer the medication ordered above. ☐ yes ☐ no

I request and authorize that the above-named student be administered or self-administer this oral medication according to the instructions indicated above from ___/___/___ to ___/___/___ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

Date of Signature

Licensed Health Professional

Phone / FAX

Name (Print) Clinic

PARENT or GUARDIAN
To complete this section

I request and authorize the school to administer medication to the above student in accordance with the LHP's instructions for the period from ___/___/___ to ___/___/___ (not to exceed the current school year). I understand that information about this medication and health problem will be shared with school staff that need to know.

My child can carry and self administer this medication at school ☐ yes ☐ no

If I give permission for my child to carry and self-administration medication, I understand and agree that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the student.

Date of Signature

Parent/Guardian Signature

Home Phone

Work or Cell Phone

Reviewed by OKSD RN/LPN: _____ on ___/___/___