AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name____ Birthdate_______________

School:________________________________ Grade:_______________

THIS PORTION TO BE COMPLETED AND SIGNED BY THE LICENSED HEALTH PROFESSIONAL IF IT IS NECESSARY TO DISPENSE MEDICATION DURING SCHOOL HOURS

Name of Medication:	Dosage:	Methods of Administration:	Time of Day Taken:
____________________	__________	____________________	____________________

If prn specify the length of time **between doses**:____

Reason for medication to be given during school hours____

____

Permission to carry: INHALER: YES ☐ NO ☐ EPI-PEN: YES ☐ NO ☐ INSULIN: YES ☐ NO ☐

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. There exists a valid health reason which makes administration of the medication advisable during school or during such time that the student is under the supervision of school officials. Such medication may be administered by trained school personnel.

_______________ ____

Date of signature Licensed Health Professional

_______________ _______________ ____

Phone FAX Name (Please print or type)

____

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 <u>ORIGINAL CONTAINER</u>; <u>AND</u> THE WRITTEN AUTHORIZATION <u>MUST MATCH EXACTLY</u> THE INFORMATION ON THE CONTAINER.

_______________ ____ _______________/_______________

Date of Signature Signature Home Phone Work Phone

REVIEWED BY RN__________________________(school nurse) **DATE** _______________