Authorization for Administration of Medication - Overnight/Extended Trip

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH CARE PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY.

Student Name _____ Birthdate _____ Grade _____

School _____ Club/Team/Activity _____ Advisor _____

The school district accepts no responsibility for untoward reactions when the medication is given in accordance with the directions of the student's health care provider.

Name of Medication	Dosage	Time to be taken	Refrigeration	Diagnosis/reason for Medication
_____	_____	_____	☐Yes ☐No	_____
_____	_____	_____	☐Yes ☐No	_____
_____	_____	_____	☐Yes ☐No	_____
_____	_____	_____	☐Yes ☐No	_____

Form of medication/treatment: ☐Tablets/Capsules ☐Liquid ☐Inhaler ☐Injection ☐Nebulizer ☐Other_____

Possible side effects of medication: ☐None anticipated ☐Yes, please describe_____

If given PRN, specify the length of time between doses: _____

Are any of these medications considered addictive or a controlled substance? ☐Yes:_____ ☐No
If medication is a controlled substance, it must be carried and administered by a teacher or district employee.

Permission to carry and self-administer: Inhalers: ☐Yes ☐No Insulin: ☐Yes ☐No Epi-Pen: ☐Yes ☐No
To be able to self-administer a medication the student must be able to: Identify the medication, state its purpose, the correct dose, when to take the medication and what to do if the medication is missed.

Emergency procedure in case of serious side effects: _____

I request and authorize that the above-named student be administered the identified medication in accordance with the instructions indicated from _____ (Date) to _____ (Date) as there exists a valid health reason which makes administration of the medication advisable during the overnight/extended trip.

_____ _____
Licensed Health Professional Signature **Date of signature**

_____ _____
Please print name **Phone number**

Please note: If samples of medication are to be given, they must be labeled with the student's name. dosage and time to be given. The medication is to be furnished in the original prescription or over-the-counter container.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request the school administer medication to the above-named student in accordance with the LHP's instructions, for the period from _____ (Date) to _____ (Date-not to exceed dates of trip). I understand that if there is any leftover medication that I do not pick up by the last day of school, it will be destroyed. You have my permission to communicate freely with this health care provider.

Permission to self-carry inhaler: ☐ Yes ☐ No Permission to self-carry epi-pen: ☐ Yes ☐ No

Permission to self-administer medication: ☐ Yes ☐ No

_____ _____
Parent/Guardian Signature **Date of signature**

_____**Cell/home** _____ **Work**
Phone number