Flushing Community Schools
Authorization to Administer Medication at School
***Required* for all Prescription and Non-Prescription Medication**

School: ○Flushing High School ○Flushing Middle School
○ Elms Elementary ○ Springview Elementary ○ Central Elementary ○ Seymour Elementary
○ Early Childhood Center

Student's Name _____ Date of Birth _____ Grade _____

Teacher / Classroom _____
(Elementary)

(To be completed by the physician or authorized prescriber)

Name of Medication _____

Reason for Medication (Optional) _____

Form of Medication/Treatment ○ Tablet/Capsule ○ Liquid ○ Inhaler ○ Injections ○ Nebulizer ○ Other

Instructions (frequency/time and **dose** to be given at school)_____

_____

Per administrative discretion, select cases may be reviewed and permission granted to self-administer medication with principal, physician and parent approval and per school policy:

○ No ○ Yes (Supervised) ○ Yes

This student may carry and is responsible for self-administering an inhaler, per school policy: ○ No ○ Yes

This student may carry and has been instructed on how to self-administer an epi pen/epinephrine auto injector, per school policy: ○ No ○ Yes

Start: ○ Date form received **Other Dates:**_____

Stop: ○ End of School Year **Other Date/Duration:**_____

○ For episodic/emergency events only

Restrictions and/or important side effects: ○ None anticipated ○ Yes

If "Yes", please explain _____

_____

Special storage requirements: ○ None ○ Refrigerate ○ Other

Please indicate if you have provided additional information:

○ On the back side of this form ○ As an attachment

Physician's Signature _____ **Date** _____

Physician's Name_____

Address_____

_____

Phone Number_____ Fax Number_____

To be completed by Parent/Guardian:

I request that_____receive the above medication at school according to standard school policy.
(Name of Child)

I give permission for exchange of verbal and written communication between the physician and the school nurse and/or designated school staff regarding my child's medication regimen. I request that my child be assisted in taking the medicine(s) described above at school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician.

Signature_____ **Date**_____
(Parent/Guardian)

Home Phone _____ **Emergency Phone** _____