

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** _____