Flushing Community Schools

2024-2025

AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

***REQUIRED* for ALL Prescription and Non-Prescription Medication**

SCHOOL	
ECC	Central
Elms	Seymour
Spvy	
FMS	FHS

Student's Name: ______________________ Date of Birth: ______________

Teacher: ______________________ Grade: ______________
(Elementary Only):

To Be Completed by 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 & **dose** to be given at school): ______________________

____

Start: ○ Date Form Received **Stop:** ○ End of School Year **Or:** ○ For Episodic/Emergency Events Only

Other Dates/Duration: ______________________

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 of this form ○ As an attachment

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 (Unsupervised)
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 how to self-administer an epi pen/epinephrine auto injector, per school policy:	○ No	○ Yes

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:** ______________

ADDITIONAL INFORMATION

Signature: ______________________________ **Date:** ______________________________
(Parent/Guardian)