

Authorization for Administration of Medication at School

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

This Portion to Be Completed By the Licensed Health Professional

Name of Medication	Dosage	Method of Administration	Time(s) to Be Taken
_____	_____	_____	_____

Diagnosis or reason for medication: _____

If given PRN, specify the minimum length of time between doses and when to administer: _____

May the student carry this medication on his/her person and self-administer? _____ Yes* _____ No

*If a health professional and a student's parent request that a student be permitted to carry his/or her own medication and/or be permitted to self-administer the medication, the principal may grant permission after consulting with the school nurse. The process for requesting and providing instructions will be the same as established for oral medications. The principal and nurse will take into account the age, maturity and capability of the student; the nature of the medication; the circumstances under which the student will or may have to self-administer the medication and other issues relevant in the specific case before authorizing a student to carry and/or self-administer medication at school (BP:3416P).

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above from _____ (date) to _____ (date) **(not to exceed current school year)**.
There exists a valid health reason which may make administration of the medication advisable during school hours.

Licensed Health Professional Signature	Date
_____	_____

Name (please print)	Phone	Fax
_____	_____	_____

El padre o tutor debe completar esta sección

- Solicito que este medicamento se administre según las instrucciones del profesional de la salud certificado.
- Autorizo al personal de los Servicios sanitarios a comunicarse con el consultorio médico para obtener información sobre este medicamento. Entiendo que la administración de medicamentos por vía oral pueda estar a cargo de miembros del personal no certificados que se capacitaron y están bajo la supervisión de un/a enfermero/a certificado/a.
- La información sobre el medicamento puede compartirse con el personal de la escuela que trabaja con mi hijo y con el personal del 911, si se llama a este número.
- Todos los medicamentos provistos deben entregarse a la escuela en su envase original junto con las instrucciones, como lo indicó anteriormente el profesional de la salud certificado.

Solicito y autorizo a mi hijo a llevar consigo o autoadministrarse su medicamento. _____ Sí _____ No

Firma del padre/tutor	Fecha
_____	_____

N.º de teléfono: N.º de tel. particular: _____ N.º de tel. laboral: _____ N.º de teléfono celular: _____

Revisado por un/a enfermero/a certificado/a: _____ Fecha: _____