

School Year: _____

**PHYSICIAN ORDER AND PARENT/GUARDIAN AUTHORIZATION
FOR EMERGENCY AND/OR SELF-ADMINISTERED MEDICATION**

(Please complete one for each of your students' medications)

Student's Name: _____	DOB: ____/____/____
Allergies: _____	
Reason for medication or diagnosis: _____	
Medication: _____	Dosage: _____
Parent Signature: _____	

PHYSICIAN'S ORDER

I have examined this student for (diagnosis) _____ and have determined that he/she requires medication during school hours.	
Name of Medication: _____	
Dosage & Route: _____	
I believe this student is able to carry and administer their own medication at the appropriate time and in the appropriate way. (Note: Lower School students may not self-administer medications.) Please circle: Yes No	
Physician's Signature: _____	Date: ____/____/____
Printed Name: _____	Phone: _____

For students to self-administer medication at school, the Parent/Guardian shall provide all information above and authorization below. This authorization is valid for one school year and must be renewed at the beginning of each new school year.

*Only middle and upper school students are allowed to carry and self-administer their medication. For elementary-age children, inhalers and emergency medications are kept in the Red Backpack. The student's teacher will provide monitoring for the child's safety.

PARENT/GUARDIAN STATEMENT (MS and US Only)

I, the undersigned Parent(s)/Guardian(s) of _____ give consent for **my student to self-administer** the above medication(s). I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance. I understand that self-administered medication is not provided by or monitored by the School Nurse or school staff.

The School Nurse reserves the right to monitor students periodically during the school year.

***Parent/Student is responsible for having the medication available at school.**

X _____ Date Signed: ____/____/____
(Parent/Guardian Signature)

Home Phone: _____ Work: _____ Cell: _____

REVIEWED BY: _____ RN DATE: ____/____/____