MISSOULA COUNTY PUBLIC SCHOOLS

Authorization for Medications or Treatments

(Order only medications/ treatments that are **required during** school hours)

Healthcare Provider Section

Name of Student: _____**Date of Birth:** _____

School: _____ **Grade:** _____

*** Medication:** _____**Dosage:** _____

* If medication is for asthma rescue or anaphylaxis, please use Asthma/ Quick Relief Bronchodilator Medication Authorization or Anaphylaxis Action Plan forms.

Purpose of Medication: _____

Administration time of medication: _____

If medication or treatment is not taken at the above time (+/- 30 minutes), how late may it still be given?

_____

Possible side effects: _____

_____

Duration of Order: Valid until end of school year unless otherwise noted. **Other length of duration:** _____

_____/ _____/ _____/_____

Provider Signature Date Phone PRINTED NAME OR STAMP

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Parent/Guardian Section

- I give my permission for the above named student to take the above medication at school as ordered.
- I understand that the medication will be given to my child by a school nurse or a school staff member.
- I will bring the medication to school myself or by another responsible adult.
    - Students are not allowed to carry medication unless allowed to do so by law or specific school plan.
- I will bring the medication to school in the original container, appropriately labeled by the pharmacy stating the name of the medication, the dosage, and the student's name.
    - Over the counter medication must be brought to school in its original container with label intact.
- I agree to health care provider (doctor) and school nurse communication based on this medical authorization if needed. Communication, if needed, may only include the medication or treatment itself, implementation of the treatment in school and student outcomes of the treatment.
- I understand that I need to pick up unused medication or the school will discard the medication at the end of the school year or after one month of discontinuing.

_____/ _____

Parent/Guardian Signature Date

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School Nurse Section

_____/_____

Date Order Reviewed School Nurse Signature

Revised December 2017