



Authorization for Administration of Medication at School

Name of Student: _____ Birthdate: _____

School: _____ School Year: _____ Grade: _____

Medical Condition / ICD 10 CM	Medication	Strength mg/ml	Dose # Tablets	Time(s) Frequency	Route	Start Date	Stop Date

(All authorizations expire one year from date)

Student may self-carry/administer emergency medication(s) (ie. inhaler, epinephrine, glucagon) with an MD order, Parent/Guardian authorization and if appropriate as determined by the School Nurse. Self-Carry privilege may be revoked, at any time, if the student is unable to maintain procedural safeguards with the above medications. (Self-carry/administer of emergency medications is for Grades 6-12 ONLY. Elementary grades is a case-by-case basis, determined by the District Nurse)

Print or Type Name of Physician / Licensed Prescriber	Signature of Physician / Licensed Prescriber
Clinic Address	Fax Number
	Phone Number
	Date

Parent / Guardian Authorization

- I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request that the medication(s) be given on field trips, as prescribed and per district policy/procedure.
- I release school personnel from liability in the event adverse reactions result from taking medication(s).
- I will notify the school, in writing, of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.).
- I give permission for the Licensed School Nurse (LSN) or designee to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
- I give permission for the medication(s) to be given by designated personnel as delegated by the LSN.
- I give permission for the LSN or designee to consult (in oral or written format) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s), as well as ongoing data on medication effects provided to physician/licensed prescriber and parent/guardian via monitoring form.**

This authorization may be revoked by you at any time in writing and automatically expires one year from signature

NOTE: Medication is to be supplied in the original/prescription bottle and transported to and from the school by a parent/legal guardian. Due to privacy issues, health information is not shared with programs that take place outside of the educational day.

Signatures must be completed in order to administer medication. If medication policy is not followed, school health services will not be able to administer medication, which may adversely affect educational outcomes or this student's safety.

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Parent/Legal Guardian Signature	Relationship to Student
Cell Phone	Date
	Day Phone