

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL-TAMAQUA SCHOOL DISTRICT

Student Name: _____ Birth Date: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP)

Name of Medication	Dosage	Route	Time
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_____	_____	_____	_____
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Diagnosis or reason for medication: _____

If given PRN, specify the minimum length of time between doses: _____

Administration time can be adjusted by parent/guardian on delays/early dismissals _____ Yes _____ No

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize this student to carry their medication (**emergency medications only**) _____ Yes _____ No

I request and authorize this student to self-administer their medication _____ Yes _____ No

I request and authorize that 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**) as there exists a valid health reason which may make administration of medication advisable during school hours.

Signature of Licensed Health Professional (LHP)

Date

Name (please print)

Telephone Number

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request this medication to be given as ordered by the licensed health professional.
- I give Health Services Staff permission to communicate with the medical office about this medication.
- Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the LHP.

I request and authorize my child to carry and/or self administer their medication (emergency medications only) _____ Yes _____ No

Parent/Guardian Signature

Date

If your provider marks that administration times can be adjusted by parent/guardian on days when the school has an early dismissal or a delayed start please fill out this section.

There will be points during the school year where our schedule will be adjusted for different reasons such as 2 hour or 3 hour delays and early dismissals.

The following section addresses if you would like your child's medication to be given on those days.

You can mark if you would like us to give the medication at a different time (example-Your child takes their medication at 1200 on a regular day before lunch but on a delayed schedule their lunch is at 1230 so you would like them to take it at 1230 on delayed days instead).

You can mark if you would like us to call you on a schedule change to determine if the medication should be given that day.

If your child gets medication at the beginning of the day or the end of the day, you can mark if you would like the medication to be given late when your student arrives on a delayed start or early in the event of an early dismissal. You can also choose for the medication to not be given on those days.

In the event of a delayed start I would like:

Medication to be given at scheduled time_____

Medication to be given at different time (include what time such as before lunch or 1pm)_____

Medication to not be given that day_____

The nurse to call to discuss administration_____

In the event of an early dismissal I would like:

Medication to be given at scheduled time_____

Medication to be given at different time (include what time such as before lunch or 1pm)_____

Medication to not be given that day_____

The nurse to call to discuss administration_____