



AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____
School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Diagnosis: _____

<u>Name of Medication</u>	<u>Dosage</u>	<u>Methods of Administration</u>	<u>Time of Day to be Taken</u>

If given PRN, specify the length of time between doses.

Student is capable to self-administer medication: 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.

Possible side effect of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize that the above-named student be administered the above-identified oral medication in accordance with the instructions indicated above from _____ to _____ (do not to exceed the current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

Health Care Provider Signature _____ Date _____

Health Care Provider (Type or Print) _____ Telephone Number _____

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from _____ to _____ (not to exceed the current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Parent/Guardian Signature _____ Date _____

Parent/Guardian (Type or Print) _____ Telephone Number _____