AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name_____ Birthdate_____

School:_____ Grade:_____

THIS PORTION TO BE COMPLETED AND SIGNED BY THE LICENSED HEALTH PROFESSIONAL IF IT IS NECESSARY TO DISPENSE MEDICATION DURING SCHOOL HOURS

Name of Medication: Dosage: Methods of Administration: Time of Day Taken:

_____ _____ _____ _____

If prn specify the length of time **between doses**:_____

Reason for medication to be given during school hours_____

_____

Permission to carry: INHALER: YES ☐ NO ☐ EPI-PEN: YES ☐ NO ☐ INSULIN: YES ☐ NO ☐

Possible **side effects** of medication:_____

Emergency procedure in case of serious side effects:_____

_____

I request and authorize that the above-named student be administered the above-identified medication in accordance with the instructions indicated above. There exists a valid health reason which makes administration of the medication advisable during school or during such time that the student is under the supervision of school officials. Such medication may be administered by trained school personnel.

_____ _____

Date of signature Licensed Health Professional

_____ _____ _____

Phone FAX Name (Please print or type)

_____

Address City Zip Code

THIS PORTION TO BE COMPLETED AND SIGNED BY THE PARENT/GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above-identified student. I request and authorize the school to administer the above identified medication to the above-identified student in accordance with the prescription or instructions from a licensed health professional.
MEDICATION MUST BE SUPPLIED TO THE SCHOOL IN THE <u>ORIGINAL CONTAINER</u>; <u>AND</u> THE WRITTEN AUTHORIZATION <u>MUST MATCH EXACTLY</u> THE INFORMATION ON THE CONTAINER.

_____ _____ _____/_____

Date of Signature Signature Home Phone Work Phone

REVIEWED BY RN_____(school nurse) **DATE** _____