

Authorization for Medication Administration by School Personnel

Student Name: _____ DOB: _____ Grade: _____

I am giving school personnel permission to administer medications to my child per the following:
Parent or Physician please complete:

<p>Medication: _____</p> <p>Dose (how much): _____ Tablets requiring cutting should be cut by the parent before being sent to school. Liquid medication requires dosage spoons or cup to be supplied by parent.</p> <p>Route: (circle one) By: Mouth Ear Eye Nose Skin Inhalation Rectal Injectable</p> <p>Time to be given at school: _____</p> <p>Reason for Medication: Check one: <input type="checkbox"/> Prolonged Seizure <input type="checkbox"/> Severe Allergic Reaction <input type="checkbox"/> Severe Hypoglycemic Reaction <input type="checkbox"/> Other (describe) _____</p> <p>Begin Date _____ End Date _____</p>	<p>Expiration date of medication _____</p> <p><input type="checkbox"/> Non-prescription</p> <p><input type="checkbox"/> Please allow my child to self-administer this medication. (refer to district policy on self medication). If prescription, consent of physician is required (See Below)</p> <p><u>ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.</u></p> <p>Special Instructions: _____</p> <p>_____</p>
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I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded. Parent must notify school of any doses of OTC medications that are given prior to the school day to avoid overmedicating the student (ie. If student takes a pain reliever before coming to school)

Parent/Guardian Signature: _____ Date: _____
(This authorization applies only to this medication listed above and for the duration of treatment or school year). This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.

PHYSICIAN DIRECTION

(Required in writing or on pharmacy label for all prescription medications).

- I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate.
- Please allow this student to carry and self-administer this medication. (Must be allowed by school district policy. Student must be developmentally and behaviorally able to self-administer).
- Special instructions including adverse reactions and action required: _____

Physician's Name (please print/stamp)	Address	Zip Code
(Physician's Signature)	(Phone#)	(Effective Date)