

## AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Name of Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_

School: \_\_\_\_\_ School Year: \_\_\_\_\_ Grade: \_\_\_\_\_

Medical Condition	Medication	Strength	Dose	Time	Route	Possible Side Effects
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1.						
2.						
3.						
4.						

Other Considerations / Directions: \_\_\_\_\_

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_  
 (All authorizations expire at the end of the school year.)

- Student is knowledgeable about the medication and how to administer it.
- Student has the skills to safely possess and use an inhaler.
- Student may self-administer the medication. (Not applicable for controlled substances.)

\_\_\_\_\_  
 (Print or Type Name of Physician / Licensed Prescriber)

\_\_\_\_\_  
 Physician's / Licensed Prescriber's Signature

\_\_\_\_\_  
 Clinic Address

\_\_\_\_\_  
 Phone Number

\_\_\_\_\_  
 Date

### Parent / Guardian Authorization

1. I request at the above medication(s) be given during school hours as ordered by this student's physician / licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.).
4. I give permission for the school nurse to communicate with the student's teacher about the student's health condition(s) and the action of the medication(s).
5. I give permission for the school nurse to consult with the above named student's physical / licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

My son/daughter may self-administer his/her medication. (Not applicable for controlled substances, such as Ritalin, Dexedrine, Codeine, etc.)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent / Guardian Signature

\_\_\_\_\_  
 Relationship to Student

**NOTE: Medication is to be supplied in the original / prescription bottle.**