

MEDICATION ADMINISTRATION AUTHORIZATION AT SCHOOL

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

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This section to be completed by Health Care Provider

ONE MEDICATION PER FORM

Medication: _____ Strength: _____

Dose: _____ Route: _____

Time to be given: _____ If PRN, length of time between doses: _____

If approved by school, can student self-carry and self-administer medication? YES: NO:

Anticipated action of medication: _____

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

Diagnosis _____

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

Health Care Provider Signature – NO STAMPS

Date

Printed Name

(_____) _____
Phone Number

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This section is to be completed by Parent/Guardian

As the parent/guardian, I authorize the school to administer the medication to my student in accordance with the health care provider's instructions. This order is valid only for the current school year, which includes summer school. Medication must be supplied to the school in the original container.

Signature of Parent/Guardian

Date

Printed Name

(_____) _____
Phone Number