

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

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THIS PORTION TO BE COMPLETED BY PHYSICIAN/DENTIST/PROVIDER
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<u>Name of Medication</u>	<u>Dosage</u>	<u>Route</u>	<u>Time of Day</u>
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Length of time between doses: _____

Inhalers (Indicate if student must carry on his/her person): _____

Is student capable of self-administration? Yes No

Is it safe for unlicensed staff to provide this student this medication? Yes No

Possible side-effects of this medication: _____

Emergency procedure in case of serious side-effects: _____

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

Physician/Dentist/Provider signature

Physician/Dentist/Provider name printed

Telephone number

Date of Signature

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

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THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN
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I request/authorize the school to give medication to my student in accordance with the health care provider's instructions written above. I understand that unlicensed staff may be assigned to provide medication to my student, and I accept ultimate responsibility for monitoring the effects of this medication.

Permission to carry inhaler : Yes No Permission to self-administer medication: Yes No

Parent/Guardian signature

Date

Phone (work & home, please)