AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

(Please clearly print legible instructions)

Name of Medication	Dosage	Method of Administration	Time(s) to Be Taken
_____	_____	_____	_____

Diagnosis or reason for medication: _____

If given PRN, specify the minimum length of time between doses: _____

I request and authorize this student to carry their medication. _____Yes _____ No

I request and authorize this student to self-administer their medication. _____Yes _____ No

This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

Possible medication side effects: _____

Emergency procedure in case of serious side effects: _____

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

_____ _____

Date of Signature Licensed Health Professional (LHP)

_____ _____

Telephone Number Name **(please print)**

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request this medication to be given as ordered by the licensed health professional.
- I give Health Services Staff permission to communicate with the medical office about this medication. I understand oral medications may be administered by nonlicensed staff members who have been trained and are supervised by a Registered Nurse.
- Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must be brought to school in its original container with instructions as noted above by the licensed health professional.

I request and authorize my child to carry and/or self-administer their medication. _____ Yes _____ No

_____ _____

Date of Signature Parent/Guardian Signature

Telephone Numbers: _____(home) _____ (work) _____(cell)

Reviewed by Registered Nurse: _____ Date: _____