Medication Authorization

Student____ DOB____________________

Age_______________ Grade________________________ School year_2023-2024____

Directions for administration

Medication/treatment____

Dosage__________________________ Route______________________ Time________________________

Starting date___________________________________ Termination date_________________________________

(As indicated or end of current school year)

Purpose of medication____

Possible side effects/ Special observations to note/Special instructions for administration

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__________ Check here if you wish to be notified prior to school staff administering this as needed medication. (The office staff will not refrain from administering a medication if they are unable to reach a parent/guardian and determine there is an urgent need for a child to receive their medication.)

__________ Check here if student will self administer (Inhaler/Epi-Pen/Insulin only)
(Self-management Consent/Release Form ****link*****, Management Plan, and Action Plan must accompany this form)

I request/authorize the above-named student be administered/provided the above-identified medication/treatment in accordance with the instructions as indicated, while at school and school related activities. I give consent to the school to receive from or send to the Health Care Provider (HCP) any information concerning my child's medical condition and the above named medication. I give consent to designated licensed and unlicensed school personnel to administer the above named medication/treatment to my child. I understand it is my responsibility to furnish medication in the original container or prescription bottle. The container/bottle must be appropriately labeled by the pharmacy or HCP, stating name of medication, dosage, and instructions. I understand that only age/weight appropriate dosing of over the counter medications will be given unless accompanied by written authorization from a HCP. I understand it is my responsibility to monitor the action and side effects of the medication and ask that I be notified if the following occur ____
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Parent/Guardian Signature____
Phone: ____________________ (home) ____________________ (work) _________________ (other)

THIS PORTION TO BE COMPLETED BY HEALTH CARE PROVIDER

This medication may be safely administered by unlicensed trained school personnel. Yes__ No__
Student may self administer (Inhaler/Epi-Pen/Insulin only)
HCP requests comments from school related to this medication? Yes__ No__

Health Care Provider Signature____ Date __________________
Health Care Provider Name Printed ____ Phone _________________
Heath Care Provider Address ____

Medication Administration Log

Student____ DOB______________ Age_________ Grade_____________ School year__2023-2024_____

Medication____________________________________ Dose________________________ Route_____________________________ Time_____________________

	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb	Mar.	Apr.	May
1	-	1	-	1	1	-	1	1	-	1
2	-	-	2	2	-	-	2	-	-	2
3	-	-	3	3	-	-	-	-	3	-
4	-	-	4	-	4	-	-	-	4	-
5	-	-	5	-	5	-	5	-	5	-
6	-	6	6	6	6	-	6	-	-	6
7	-	7	-	7	7	-	7	-	-	7
8	-	8	-	8	8	8	8	-	8	8
9	-	-	9	9	-	9	9	-	9	9
10	-	-	10	10	-	10	-	-	10	10
11	-	11	11	-	11	11	-	11	11	-
12	-	12	12	-	12	12	12	12	12	-
13	-	13	13	13	13	-	13	13	-	13
14	-	14	-	14	14	-	14	14	-	14
15	-	15	-	15	15	-	-	15	15	15
16	16	-	-	16	-	16	-	-	16	16
17	17	-	17	17	-	17	-	-	17	17
18	18	18	18	-	18	18	-	18	18	-
19	-	19	19	-	19	19	-	19	19	-
20	-	20	20	-	20	-	20	20	-	20
21	21	21	-	-	21	-	21	21	-	21
22	22	22	-	-	-	22	22	22	22	22
23	23	-	23	-	-	23	23	-	23	-
24	24	-	24	-	-	24	-	-	24	-
25	25	25	25	-	-	25	-	25	25	-
26	-	26	26	-	-	26	26	26	26	-
27	-	27	27	27	-	-	27	27	-	-
28	28	-	-	28	-	-	28	-	-	-
29	29	-	-	29	-	29	29	-	29	-
30	30	-	30	30	-	30	-	-	30	-
31	31	-	31	-	-	31	-	-	-	-

NOTE TIME AND INITIALS BY DATE MEDICATION ADMINISTERED.

Initials Signature

_____ ___________________________

_____ ___________________________

Initials Signature

_____ ________________________________

_____ ________________________________

Initials Signature

_____ ________________________________

_____ ________________________________

Key
NSD: No school day
N: No medication available
W: Weekend
A: Absent
R: Refused
F: Field trip
SN: See note

Notes:

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