Medication Authorization

Student ____ DOB ____________________

Age ______________ Grade ______________________ School year 2021 - 2022

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, 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 ____
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