

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)
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Telephone Number	Name (please print)
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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
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Telephone Numbers: _____ (home) _____ (work) _____ (cell)

Reviewed by Registered Nurse: _____ Date: _____