Authorization to Administer Prescription Medication

Student_____ **Birth date** _____

School _____ **Grade** _____ **School Year** _____

Parent/Guardian 1: _____ **Parent/Guardian 2:** _____

Daytime Phone (____) _____ **Daytime Phone (____)** _____

Cell (____) _____ **Cell (____)** _____

Authorization expires at the end of the school year or following the summer school session.

Parent/Guardian Medication Consent:

I give permission for my son/daughter to receive the medication listed below. I also give permission for an exchange of information between school district personnel and the health care provider, if necessary, regarding this medication. I agree to notify the school in writing at the withdrawal of this request or when a change in this medication occurs.

I understand that it is my responsibility to:

- **Transport the medication to school in the original *pharmacy-labeled* container (4K through 8th grade)**
- Replace the supply of medication when needed
- Pick up medication or direct staff to discard remaining medication upon discontinuation or at the end of the school year

Health Care Provider's Order for Medication to Be Given at School

Medical Condition:	
Name of Medication: (generic and trade)	
Dosage of Medication:	_____mg / cc / tsp _____ drops / puffs Form: □ Tablet / Capsule □ Liquid □ Inhaler □ Nebulizer □ Other _____
Route:	□ Oral □ Eyes □ Ear □ Nose □ Topical □ Rectal □ Other _____
Administration Time:	□ **Daily at:** _____ □ **As needed** – Describe frequency & symptoms for which medication should be given: _____ □ May be repeated in _____ minutes/hours. (time)
Possible Side Effects:	
For inhaled asthma medication ONLY:	□ In my professional opinion, this student should be allowed to carry and use this medication by him/herself. □ In my professional opinion, this student ***SHOULD NOT*** carry this medication by him/herself.

Health Care Provider's Name (Please print) _____ Phone (____)_____

Health Care Provider's Signature _____ Date _____

FOR SCHOOL USE

- Date received: _____
- Name of person(s) who will administer the Medication:

_____ _____

- Approved by: _____ _____
  (Principal's Signature) (Date)
- _____ Referred for administrative review. Send to School District Nurse with your concerns about this authorization.