



**Authorization to Administer
Prescription Medication**

Student _____ Birth date _____

School _____ Grade _____ School Year _____

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

Daytime Phone#: _____ Daytime Phone #: _____

Cell Phone #: _____ Cell Phone #: _____

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

Parent/Guardian Medication Consent:
 I give permission for my child 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

 Parent/Guardian Signature _____
 Date

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 Inhaler Other	Liquid Nebulizer
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 <i>SHOULD NOT</i> carry this medication by him/herself.		

Health Care Provider's Name (please print) _____ Phone #: _____

Health Care Provider's Signature _____ Date _____