Health and Nursing Services

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AUTHORIZATION FOR STUDENT MEDICATION

To the Principal of ________________________________School Date: _________________

I, the parent / guardian of __________________________________, whose birth date is __________________, request the following medication be given to my child during school hours. I release school personnel from any liability involved with administering this medication according to the doctor's instructions below. I understand that this form is valid only with a licensed medical provider's signature. I authorize the school nurse and the medical provider to communicate as need to ensure the safe administration of the medication. I UNDERSTAND THAT THIS AUTHORIZATION IS IN EFFECT FOR ONE YEAR AND A NEW FORM MUST BE SIGNED BY A MEDICAL PROVIDER EACH SCHOOL YEAR.

___________________________ _____________________________ ________________
Parent signature Parent's Printed Name Date

ONLY ONE MEDICATION PER SHEET

In accordance with the request of the parent above I request that the following medication be administered to _______________________________________ by school personnel during regular school hours:

Diagnosis: ______________________________ Duration to be given: ______________________________

Medication: ____Dosage: ________________________________

Time: ___________________________________ Route: ____

Potential side effects of these medications the school staff needs to be aware of: ____________________________

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Additional instructions to the school: ____

Only asthma inhalers, epinephrine and diabetic medications / supplies can be carried by a student at school. Self-Administration forms for these medications must be on file with the school.

1) Do you recommend that any of these medications be kept with the student at all times? If so, which:
   ________ Asthma inhaler _______epinephrine _______diabetic medications / supplies
2) Student has been trained to self-administer medication and are they capable of doing this safely: **YES** **NO**

__________________________________ ________________________________ ______________
Physician Signature Physician's Printed Name Date

__________________________________ _____________________
Signature of School Nurse Date

Staff members assigned to administer the above medications:

1.____________________________ 2.______________________________ 3.___________________________