AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name_____ Birthdate _____
School _____ Grade _____

THIS PORTION TO BE COMPLETED BY THE PRESCRIPTIVE LICENSED HEALTH PROFESSIONAL

Whenever possible, the parent and prescriptive licensed health professional will design a schedule for giving medication outside of school hours.

Name of medication	Dosage	Time to be taken
_____	_____	_____
_____	_____	_____

Route of medication_____
**If emergency medication (Glucagon; Anti-Seizure, etc.), name *situation* for which meds are to be given_____

If given prn, specify the length of time between doses _____
Inhalers _____

Indicate if student must carry on his/her person

Student is capable to self-administer medication _____ Yes _____ No
Possible side effects of medication _____
Emergency procedure in case of serious side effects _____
_____

I request and authorize that the above-named student be administered the above identified medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours. **This medication may be administered by trained non-licensed/non-medical school personnel.**

_____ _____
Date of Signature Prescriptive Licensed Health Professional

Telephone number (____)_____ Name_____
Print or type

Please note: If samples of medication are to be given, they must be labeled with the name of the student, dosage and time to be given.

PARENT TO COMPLETE THIS PORTION

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period _____ to _____ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner. **This medication may be administered by trained non-licensed/non-medical school personnel. All medication will be supplied in the original container.**

Permission to carry inhaler (with prescriptive licensed health professional approval) ____ Yes____ No
Permission to self-administer medication (with prescriptive licensed health professional approval) _____ Yes _____No

_____ _____
Date of signature Parent/Guardian signature

Telephone number (_____)_____(home) (_____)_____(work)
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