

Authorization for Administration of Medication at School

Name of Student: _____ Birthdate: ____/____/____

School: _____ School Year: _____ Grade: _____

Fax: _____

Medical Condition	ICD 10 Code	Medication	Strength	Dose	Time	Route	Possible Side Effects
1							
2							
3							
4							

Other Considerations/Directions: _____

Start Date: _____ Stop Date: _____

(All authorizations expire at the end of the school year.)

- Student is knowledgeable about the medication and how to administer it.
- Student may carry and self-administer the medication. **(Not applicable for controlled substances.)**

Print or Type Name of Physician/Licensed Prescriber

Physician's/Licensed Prescriber's Signature

Clinic Address

() _____
Phone Number Date

() _____
Fax Number

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
 2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
 3. I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.)
 4. I give permission for the school nurse to communicate with the student's teachers about the action and side effects of this medication(s).
 5. I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
 6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
- My son/daughter may carry and self-administer his/her medication. **(Not applicable for controlled substances.)**

Date

Parent/Guardian Signature

Relationship to Student

NOTE: Medication is to be supplied in the original/prescription bottle/container.