

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name _____ Birthdate _____
School _____ Grade _____

**THIS PORTION TO BE COMPLETED AND SIGNED BY THE LICENSED HEALTH PROFESSIONAL
IF IT IS NECESSARY TO DISPENSE MEDICATION DURING SCHOOL HOURS**

Name of Medication _____ Dosage _____ Methods of Administration _____ Time of Day to be Taken _____

If prn specify the length of time between doses: _____

Reason for medication to be given during school hours: _____

Permission to carry (circle) Inhaler: YES ___ NO ___; EpiPen: YES ___ NO ___;
Insulin: YES ___ NO ___ (insulin injection may not be delegated to unlicensed staff)

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 _____. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by trained school personnel.

Date of Signature _____ Licensed Health Professional _____

Phone _____ FAX _____ Name (Please Print or Type) _____

Address _____ City _____ Zipcode _____

THIS PORTION TO BE COMPLETED AND SIGNED BY THE PARENT/GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or instructions from a licensed health professional.

MEDICATION MUST BE SUPPLIED TO THE SCHOOL IN THE ORIGINAL CONTAINER; AND THE WRITTEN AUTHORIZATION MUST MATCH EXACTLY THE INFORMATION ON THE CONTAINER.

I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed. Permission granted to exchange medication information with the nurse.

Date of Signature _____ Signature _____ Home Phone _____ Work Phone _____

REVIEWED BY _____ (SCHOOL NURSE) Date _____

STUDENT MEDICATION, SCHOOL YEAR: 20__ - 20__

STUDENT NAME _____

TEACHER _____

MEDICATION _____

DOSAGE _____

TIME _____

Rx BEGINS _____

Rx ENDS _____

<p>SEPTEMBER</p> <p>01 _____ 21 _____</p> <p>02 _____ 22 _____</p> <p>03 _____ 23 _____</p> <p>04 _____ 24 _____</p> <p>05 _____ 25 _____</p> <p>06 _____ 26 _____</p> <p>07 _____ 27 _____</p> <p>08 _____ 28 _____</p> <p>09 _____ 29 _____</p> <p>10 _____ 30 _____</p>	<p>OCTOBER</p> <p>01 _____ 11 _____ 21 _____</p> <p>02 _____ 12 _____ 22 _____</p> <p>03 _____ 13 _____ 23 _____</p> <p>04 _____ 14 _____ 24 _____</p> <p>05 _____ 15 _____ 25 _____</p> <p>06 _____ 16 _____ 26 _____</p> <p>07 _____ 17 _____ 27 _____</p> <p>08 _____ 18 _____ 28 _____</p> <p>09 _____ 19 _____ 29 _____</p> <p>10 _____ 20 _____ 30 _____</p> <p>31 _____</p>	<p>NOVEMBER</p> <p>01 _____ 11 _____ 21 _____</p> <p>02 _____ 12 _____ 22 _____</p> <p>03 _____ 13 _____ 23 _____</p> <p>04 _____ 14 _____ 24 _____</p> <p>05 _____ 15 _____ 25 _____</p> <p>06 _____ 16 _____ 26 _____</p> <p>07 _____ 17 _____ 27 _____</p> <p>08 _____ 18 _____ 28 _____</p> <p>09 _____ 19 _____ 29 _____</p> <p>10 _____ 20 _____ 30 _____</p> <p>31 _____</p>	<p>DECEMBER</p> <p>01 _____ 11 _____ 21 _____</p> <p>02 _____ 12 _____ 22 _____</p> <p>03 _____ 13 _____ 23 _____</p> <p>04 _____ 14 _____ 24 _____</p> <p>05 _____ 15 _____ 25 _____</p> <p>06 _____ 16 _____ 26 _____</p> <p>07 _____ 17 _____ 27 _____</p> <p>08 _____ 18 _____ 28 _____</p> <p>09 _____ 19 _____ 29 _____</p> <p>10 _____ 20 _____ 30 _____</p> <p>31 _____</p>
<p>JANUARY</p> <p>01 _____ 21 _____</p> <p>02 _____ 22 _____</p> <p>03 _____ 23 _____</p> <p>04 _____ 24 _____</p> <p>05 _____ 25 _____</p> <p>06 _____ 26 _____</p> <p>07 _____ 27 _____</p> <p>08 _____ 28 _____</p> <p>09 _____ 29 _____</p> <p>10 _____ 30 _____</p> <p>31 _____</p>	<p>FEBRUARY</p> <p>01 _____ 11 _____ 21 _____</p> <p>02 _____ 12 _____ 22 _____</p> <p>03 _____ 13 _____ 23 _____</p> <p>04 _____ 14 _____ 24 _____</p> <p>05 _____ 15 _____ 25 _____</p> <p>06 _____ 16 _____ 26 _____</p> <p>07 _____ 17 _____ 27 _____</p> <p>08 _____ 18 _____ 28 _____</p> <p>09 _____ 19 _____ 29 _____</p> <p>10 _____ 20 _____</p>	<p>MARCH</p> <p>01 _____ 11 _____ 21 _____</p> <p>02 _____ 12 _____ 22 _____</p> <p>03 _____ 13 _____ 23 _____</p> <p>04 _____ 14 _____ 24 _____</p> <p>05 _____ 15 _____ 25 _____</p> <p>06 _____ 16 _____ 26 _____</p> <p>07 _____ 17 _____ 27 _____</p> <p>08 _____ 18 _____ 28 _____</p> <p>09 _____ 19 _____ 29 _____</p> <p>10 _____ 20 _____ 30 _____</p> <p>31 _____</p>	<p>APRIL</p> <p>01 _____ 11 _____ 21 _____</p> <p>02 _____ 12 _____ 22 _____</p> <p>03 _____ 13 _____ 23 _____</p> <p>04 _____ 14 _____ 24 _____</p> <p>05 _____ 15 _____ 25 _____</p> <p>06 _____ 16 _____ 26 _____</p> <p>07 _____ 17 _____ 27 _____</p> <p>08 _____ 18 _____ 28 _____</p> <p>09 _____ 19 _____ 29 _____</p> <p>10 _____ 20 _____ 30 _____</p>
<p>MAY</p> <p>01 _____ 21 _____</p> <p>02 _____ 22 _____</p> <p>03 _____ 23 _____</p> <p>04 _____ 24 _____</p> <p>05 _____ 25 _____</p> <p>06 _____ 26 _____</p> <p>07 _____ 27 _____</p> <p>08 _____ 28 _____</p> <p>09 _____ 29 _____</p> <p>10 _____ 30 _____</p> <p>31 _____</p>	<p>JUNE</p> <p>01 _____ 11 _____ 21 _____</p> <p>02 _____ 12 _____ 22 _____</p> <p>03 _____ 13 _____ 23 _____</p> <p>04 _____ 14 _____ 24 _____</p> <p>05 _____ 15 _____ 25 _____</p> <p>06 _____ 16 _____ 26 _____</p> <p>07 _____ 17 _____ 27 _____</p> <p>08 _____ 18 _____ 28 _____</p> <p>09 _____ 19 _____ 29 _____</p> <p>10 _____ 20 _____ 30 _____</p> <p>31 _____</p>	<p>PARENT REQUEST ON FILE</p> <p>PHYSICAN REQUEST ON FILE</p> <p>DOSAGE CHANGE [NOTE DATE]</p>	