**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL**

****Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY (Please clearly print legible instructions)**

Name of Medication Dosage Method of Administration Time(s) to Be Taken

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis or reason for medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If given PRN, specify the minimum length of time between doses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize this student to carry their medication: \_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_ No

I request and authorize this student to self-administer their medication: \_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_ No

This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

Possible medication side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency procedure in case of serious side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize the above-named student be administered the above identified medication in accordance with the instructions indicated above from \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) to \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) (**not to exceed current school year**). There exists a valid health reason which may make administration of the medication advisable during school hours.

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Signature Licensed Health Professional (LHP)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number Name (please print)

**THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN**

* I request this medication to be given as ordered by the licensed health professional.
* I give Health Services Staff permission to communicate with the medical office about this medication. I understand oral medications may be administered by non-licensed staff members who have been trained and are supervised by a Registered Nurse.
* Medication information may be shared with school staff working with my child and 911 staff, if they are called.
* All medication supplied must be brought to school in its original container with instructions as noted above by the licensed health professional.

I request and authorize my child to carry and/or self-administer their medication. \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Signature Parent/Guardian Signature

Telephone Numbers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell)

Reviewed by Registered Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_