

MEDICATION AUTHORIZATION

TO THE PHYSICIAN:

When it is necessary for a student to self-administer or have the school nurse administer medication during the school day, the following directions to the school personnel/nurse from the physician are required:

_____ should take _____
(Name of student) (Dosage)

of _____ at _____ for the _____
(Name of medication) (Time of day) (period of time)

The diagnosis is: _____

The desired effect is: _____

The side effects are: _____

Signature: _____ Office Phone: _____
(Physician) (Date)

PARENT/GUARDIAN:

I hereby give my permission for my child to take _____ as
prescribed by the physician. (Name of medication)

Signature: _____ Phone _____
(Parent/Guardian Signature) (Date)

Parents/Guardians:

In order for your student to take medication at school, the following criteria must be met:

1. Medication is in labeled bottle form the pharmacy for prescription meds or the original container for the over the counter meds.
2. Label shall have name of child, name of medication, dosage to be given, time of administration, physician's name and date of prescription.
3. Only one medication per authorization form.

*The School District, along with its employees and agents, assume no liability (except for willful and wanton misconduct) as a result of any injury arising from the student's self-administration of asthma or other emergency medication.

*Information may be shared with appropriate personnel for health and educational purposes.

