

AUTHORIZATION TO ADMINISTER MEDICATION

Permission Form for Prescribed Medication and Over-the-Counter Medication.
This Authorization is Valid for the Current School Year Only.

TO BE COMPLETED BY THE PARENT/GUARDIAN

Student: _____ Date of Birth: _____ Grade: _____
School: _____ Teacher/Classroom: _____

I have read the policy and regulations pertaining to administration of medication. I request that (name of student) _____ receive the medication specified below at school according to standard school policy. I understand the parent is required to deliver medication to school.

Date Parent/Guardian Signature

Self Administration: High school students may self administer medication. Elementary and middle school students may self administer only emergency medications such as Epi Pens and inhalers with the approval of the parent and physician. I request that (name of student) _____ be allowed to self-administer the medication below at school according to school policy.

Date Parent/Guardian Signature

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER:

Name of Medication: _____

Reason for Medication (optional): _____

Form of Medication/Treatment: Tablet/Capsule Liquid Inhaler Injection Nebulizer
 Other _____

Instructions: (Times and dose to be given at school): _____

Start: Date form received Other date: _____

Stop: End of school year Other date/duration: _____

Restrictions and/or adverse reactions:

None anticipated Yes. Please describe: _____

Special storage requirements: None Refrigerate Other: _____

This student is both capable and responsible for self-administering this medication.
 No Yes, Supervised Yes, Unsupervised
This student may carry this medication: Yes No

PLEASE PRINT:

Physician's Name: _____ Date: _____

Address: _____

Phone Number: _____ Physician's Signature: _____

Office Use Only:
Date received: _____ **Received by:** _____
Administrative Approval: _____