AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Students Name:_____ Birthdate: _____

School:_____ Grade:_____

THIS PORTION TO BE COMPLETED AND SIGNED BY THE LICENSED HEALTH CARE 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: INHALER YES ☐ NO ☐ EPIPEN: YES ☐ NO ☐

INSULIN YES ☐ NO ☐ (insulin injection may not be delegated to unlicensed staff)

Possible side effects of medicine:_____

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	Signature of Licensed Health Professional	Name (Please print or type)

Phone	Fax	Address	City	Zip Code
( )	( )			

THIS PORTION TO BE COMPLETED AND SIGNED BY 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 is granted to exchange medication information with the nurse.

Date of Signature	Signature of Parent or Legal Guardian	Phone: Home	Work
		( )	( )

REVIEWED BY SCHOOL NURSE:_____ **DATE:**_____

4/22/03 (adapted from Thurston County School Health Advisory Board)