

**MEDICATION ADMINISTRATION AUTHORIZATION AT SCHOOL**

Student's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

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

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

**This section to be completed by Health Care Provider ONE MEDICATION PER FORM**

Medication: \_\_\_\_\_ Strength: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time to be given: \_\_\_\_\_ If PRN, length of time between doses: \_\_\_\_\_

<p><b>If approved by school, can student self-carry and self-administer medication?</b></p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
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Anticipated action of medication: \_\_\_\_\_

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

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

Diagnosis \_\_\_\_\_

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated. 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. Medication may be administered by non-licensed school personnel.

\_\_\_\_\_  
Health Care Provider Signature – NO STAMPS

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

(\_\_\_\_)\_\_\_\_\_  
Phone Number

**This section is to be completed by Parent/Guardian**

As the parent/guardian, I authorize the school to administer the medication to my student in accordance with the health care provider's instructions. This order is valid only for the current school year, which includes summer school. Medication must be supplied to the school in the original container.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

(\_\_\_\_)\_\_\_\_\_  
Phone Number