AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

(Please clearly print legible instructions)

Name of Medication	Dosage	Route	Time
_____	_____	_____	_____

Diagnosis or reason for medication: _____

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

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize this student to carry their medication (**inhaler only**) _____ Yes _____ No

I request and authorize this student to self-administer their medication _____ Yes _____ No

I request and authorize that 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)** as there exists a valid health reason which may make administration of medication advisable during school hours.

_____ _____

Signature of Licensed Health Professional (LHP) Date

_____ _____

Name (please print) Telephone Number

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.
- Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the LHP.

I request and authorize my child to carry and/or self administer their medication (inhaler only) _____ Yes _____ No

_____ _____

Parent/Guardian Signature Date