# Authorization and Permission for Administration of Medication

_____ _____ _____

Student's Name Birthdate School Year

School medication and health care services are administered following these guidelines:

*Physician/Prescriber signed and dated authorization to administer the medication.*
*Parent signed, dated authorization to administer the medication.*
*The medication is in the original labeled container as dispensed or the manufacturers labeled container.*
*The medication label contains the student name, name of the medication, directions for use and date.*
*Annual renewal of authorization and immediate notification, in writing, of changes.*

**Physician Authorization:**

_____ _____ _____

Medication/Health Care Treatment Dosage Time to be administered

_____ _____

Intended effect of this medication Expected side effects, if any

_____

Other medications student is taking

May student self-administer medication under supervision of School Nurse or designate?
*(The below student self-administration form must be completed)* (Please circle) YES / NO

Administration instructions

_____
_____

_____

Discontinue/Re-Evaluate/Follow-Up Date (circle one)

_____ _____

Prescriber's Signature Date signed

_____ _____

Prescriber's Emergency Phone Number Prescriber's Address

## Physician Request for Self-Administration of Medication

The above named student has_____

(Name of Disease or Diagnosis)

I am requesting that the above named student take the following medication during school hours.

_____ _____

Name of Medication Type of Medication (Tablet, Liquid, Capsule)

_____ _____

Dosage Time(s)

_____

Possible Side Effects

I certify that _____has been instructed in the use and self-administration of
(Name of Student)

_____

(Name of Medication)

May the above named student carry (in their locker or back pack) the above named medication? YES / NO
(Circle One)

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects.
He/she is capable of using this medication independently.

_____ _____

Physician's Signature Date signed

_____ _____

Physician's Address Physician's Phone Number