

# AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

## **SECTION 1: TO BE COMPLETED BY PARENT OR GUARDIAN**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

I request/authorize the school to administer medication in accordance with the doctor's instructions for the period from \_\_\_\_\_ to \_\_\_\_\_ (not to exceed the current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner. Due to staff and school schedules and other responsibilities it is permissible for a dose or dosages to be delayed or missed.

Permission to carry inhaler:  Yes  No

Permission to self-administer medication:  Yes  No

### **MEDICATION MUST BE SUPPLIED IN THE ORIGINAL, LABELED CONTAINER**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Phone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Celular)

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## **SECTION 2: TO BE COMPLETED BY THE PHYSICIAN**

<u>NAME OF MEDICATION</u>	<u>DOSAGE</u>	<u>METHOD OF ADMINISTRATION</u>	<u>TIME OF DAY TO BE TAKEN</u>
_____	_____	_____	_____
_____	_____	_____	_____

Diagnosis which requires medication at school: \_\_\_\_\_

If given prn, specify length of time between doses: \_\_\_\_\_

Inhalers: \_\_\_\_\_  
(Indicate if student must carry on hes/her person.)

Student is capable of self-administration of medication:  Yes  No

Anticipated action: \_\_\_\_\_

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

Emergency procedures 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 above instructions from \_\_\_\_\_ to \_\_\_\_\_ (not to exceed the current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours. Such medication may be administered by medically untrained school personnel.

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician Phone Number

\_\_\_\_\_  
Please Print Physician's Name

\_\_\_\_\_  
Physician Address