AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER (LHCP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY (Please COMPLETE ALL AREAS)

Name of Medication	Dosage	Method of Administration	Time to Be Taken
_____	_____	_____	_____
_____	_____	_____	_____

Diagnosis or reason for medication: _____

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

I request and authorize this student to carry their (Non-scheduled) medication. ____Yes ____ No

I request and authorize this student to self-administer their (Non-scheduled) medication. ____Yes ____ No

In agreeing that this student may self-administer medication, I concur that this student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

Possible side effects of medication: _____

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 _____ **(date)** to _____ **(date) (not to exceed current school year)** as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____
Licensed Health Care Provider (LHCP) Date of Signature

_____ _____
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 Care Provider. The medication is to be furnished by me in the original container and **brought to school by an adult.** Prescription medications must be labeled with the name of the student, medication, dosage, time of day to be given and the name of the prescribing health care provider. Over-the-counter medication must be labeled in the same manner.
- Any change in medication or dose or time must be handled as a new medication, and a new form completed by both the parent and health care provider.
- I understand that oral medications may be administered by non-licensed staff members who have been trained and are supervised by the Registered Nurse/ School Nurse.
- Written requests and authorizations must be renewed each school year.

I request and authorize my child to carry their medication. ____ Yes ____ No
I request and authorize my child to self-administer their medication. ____ Yes ____ No

_____ _____
Parent/Guardian Signature Date of Signature

Telephone Numbers: _____(home) _____ (work) _____(cell)

Registered Nurse Reviewed: _____