MEDICATION AUTHORIZATION

_____ _____ _____
(Student's Name) *(Birthdate)* *(School)*

TO THE PHYSICIAN:
When it is necessary for a student to self-administer or have the school nurse/personnel administer medication during the school day, the following directions to the school nurse/personnel from the physician are required:

_____ _____ _____
(Name of Medication) *(Dosage)* *(Time Administered)*

The diagnosis is: _____.

The desired effect is: _____.

The side effects are: _____.

Administration Instructions: _____

_____.

May student self-administer medication under supervision of school nurse/personnel?
Please Circle: YES / NO

Signature: _____ Office Phone: _____ Date: _____
(Physician)

PARENT/GUARDIAN
I hereby give my permission for my child to take _____ as prescribed by the physician.
(Name of Medication)

Signature: _____ Phone: _____ Date: _____
(Parent/Guardian Signature)

In order for your student to take medication at school, the following criteria must be met:

1. Medication is in properly labeled bottle from the pharmacy for prescription medications or the original container for over the counter medications.
2. Label shall have name of child, name of medication, dosage to be given, time of administration, physician's name and date of prescription.
3. Only one medication per authorization form.

*The School District, along with its employees and agents, assume no liability (except for willful and wanton misconduct) as a result of any injury arising from the student's self-administration of asthma or other emergency medication.
*Information may be shared with appropriate personnel for health and educational purposes: