STUDENT AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ **Birth Date:** _____
School: _____ **Grade:** _____

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

Name of Medication	Dosage	Method of Administration	Time of Day to be given
_____	_____	_____	_____
_____	_____	_____	_____

Diagnosis or reason for medication: _____

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

Emergency procedure in case of serious side effects: _____
_____

Student may carry and/or self-administer this medication during school hours: _____Yes _____No
ANY STUDENT WHO NEEDS TO CARRY AND SELF ADMINISTER AN INHALER OR EPIPEN MUST HAVE AN EXCEPTION FORM ON FILE. (See reverse side)

I request and authorize that the above named student be administered the above identified oral medication in accordance with the instructions indicated above from this date _____(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 Professional Signature Name (printed)

_____ _____
Date Name of Clinic/Hospital Name/Urgent Care

_____ _____
Telephone Number Address

Please note: If samples of medication are to be given, they must be labeled with the name of the student, Dosage, and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I certify that I am the parent/legal guardian of the above identified student and I request/authorize the school to administer medication to the above-identified student in accordance with the LHP's instructions for the period from _____to _____ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner

Permission to carry inhaler (if authorized by LHP) _____Yes _____No
Permission to self-administer medication (if authorized by LHP) _____Yes _____No

MEDICATION SUPPLIED TO SCHOOL IN ORIGINAL CONTAINER WITH PHARMACY LABEL

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Telephone Number (home) **Telephone number (work or cell)**