AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name _____ Birth Date _____

Grade _____

This portion to be completed by the Health Care Provider – Please complete all areas.

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

Diagnosis or reason for medication _____

If given PRN, specify the symptoms for medication _____

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

Student may carry inhaler on his/her person ☐ Yes ☐ No ☐ N/A

Student demonstrated correct inhaler use ☐Yes

Student may carry epi-pen or his/her person ☐ Yes ☐ No ☐ N/A

Possible side effects of medication _____

Emergency procedures in case of serious side effects _____

I request and authorize the above named student be administered above identified medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year), as there exists a valid health reason which makes administration of the medication advisable during school hours.

Name of Health Care Provider _____ Date _____
(Please print name)

_____ Phone No. _____
(Signature of Health Care Provider)

Fax No. _____

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 request/authorize the school to administer medication to the above identified student in accordance with the Health Care Provider's instruction 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	☐ Yes	☐ No	☐ N/A
Permission to carry epi-pen	☐ Yes	☐ No	☐ N/A
Permission to self–administer medication	☐ Yes	☐ No	

Home No. _____ Cell No. _____ Work No. _____

Parent/Guardian Signature _____ Date _____