AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name _____ Birth Date _____

School _____ Grade _____

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

Name of Medication	**Dosage**	**Methods of Administration**	**Time of Day To beTaken**
_____	_____	_____	_____
_____	_____	_____	_____

Diagnosis or reason for medication: _____

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

Inhalers: _____

Indicate if student will carry on his/her person

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

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 oral 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.

_____ _____

Date of Signature Licensed Health Professional

_____ _____

Telephone Number Name (Print or Type)

Please Note: Medication must be in original prescription container labeled with student's name, dosage, time to be administered and expiration date. Parent/Guardian must deliver to school for documentation.

PARENTS HAVE THE RESPONSIBILITY FOR MAINTAINING THE SUPPLY OF MEDICATION TO BE DISPENSED.

PARENT/GUARDIAN MUST COMPLETE AUTHORIZATION ON BACK ➔

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

PARENTS ARE RESPONSIBLE FOR MAINTAINING THE SUPPLY OF MEDICATION TO BE DISPENSED.

I request/authorize the school to administer medication to _____
Student's Name

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 _____ Yes _____ No

Permission to self-administer medication _____ Yes _____ No

_____ _____
Date of Signature Parent/Guardian Signature

Telephone Number _____(home) _____ (work)