

PARENT AND PRESCRIBER'S AUTHORIZATION FOR

ADMINISTRATION OF MEDICATION IN SCHOOL

AUTHORIZATION FOR ADMINISTRATION OF MEDICINE

A. To be completed by the parent or guardian:

I request that my child _____ Grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other assigned person will administer the medication.

Signature (Parent or Guardian) _____

Address _____

Telephone/Home _____ Work _____ Date _____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ Date of Birth _____

Diagnosis _____

Name of Medication _____

Prescribed Dosage, Frequency and Route of Administration:

Time to be taken during school hours _____

Duration of treatment _____

Possible side effects and adverse reaction (if any) _____

Other recommendations _____

Name of Licensed Prescriber and title (please print) _____

Prescriber's signature _____ Date _____

Address _____ Telephone _____

SELF MEDICATION RELEASE FORM

Date _____

Child's Name _____

has been instructed in the proper use of the following medication procedures: _____

We (Physician's signature) _____

and (Parent or Guardian signature) _____

request the (Child's name) _____ be permitted to carry the medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of use.

Note: This form must be completed *in addition* to routine district medication form for those students who request permission to carry their own medication on campus or keep this medication in a P.E. locker.
