

AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL
(Prescription and Over-the-Counter Medications)

Student Name _____ DOB ____ / ____ / ____

Grade / Teacher _____ Date Received _____

THIS SECTION TO BE COMPLETED BY A PHYSICIAN

Name of Medication: _____

Reason for Medication: (Optional) _____

Form of Medication: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions: (frequency/time & dose) _____

Possible Side Effects: ☐ None Anticipated ☐ Yes, explain _____

Special Storage: ☐ None ☐ Refrigerate ☐ Other _____

Start Date: ☐ Once both medication & completed form are received ☐ Other Date _____

Stop Date: ☐ End of school year ☐ Other Date _____

Self-Administration

This student is capable and responsible for carrying and self-administration of this medication.

☐ Yes ☐ No ☐ Yes, with supervision (may self-administer, medication to remain with staff)

Physician Name _____ Date _____

Physician Signature _____ Phone _____

THIS SECTION TO BE COMPLETED BY A PARENT/GUARDIAN

I request that (student name) _____ receive the above medication according to school policy. I give permission for exchange of verbal and written communication between the physician and designated school staff regarding my child's medication. I request the my child be assisted in taking the medication described above or be permitted to carry and self-administer as authorized by the physician listed on this form.

Parent/Guardian Name _____ Date _____

Parent/Guardian Signature _____ Phone _____

- One *Authorization to Administer Medication at School* form must be filled out for EACH medication the student may take at school.
- Additional forms available in the school office.

FOR OFFICE USE ONLY

☐ Dr. signed ☐ Parent signed ☐ Med received (and/or) ☐ Student carries