

# Authorization for Administration of Medication at School

Parents/guardians asking school staff to give medications to their child must provide (written) permission every school year that has been signed by parent/guardian **and** the child's health care provider.

## Physician Authorization

Student: \_\_\_\_\_ BD: \_\_\_\_\_ Grade \_\_\_\_\_

School: \_\_\_\_\_ School Year: \_\_\_\_\_ Teacher \_\_\_\_\_

Physician/licensed prescriber's orders for administration of Medication by School Personnel

Medical Condition	Medication	Dose	Time	Route	Possible Side Effects
1.					
2.					

Other considerations-directions: \_\_\_\_\_

Medication **ALLERGIES**: \_\_\_\_\_

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

(All Authorizations expire at the end of the school year or following the summer school session)

\_\_\_\_\_  
SIGNATURE of Physician/Licensed Prescriber      PRINT name of Physician/Licensed Prescriber      Date

\_\_\_\_\_  
Clinic Address      Phone      Fax

## Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by my child's Physician/Licensed Prescriber.
2. **All medications sent to school will be in an appropriately labeled pharmacy container or an original labeled container.**
3. I also request that the medication(s) be given on field trips; as prescribed, by a teacher or other responsible adult.
4. I will notify the school of any change in the medication(s), (i.e. dosage change, medication is stopped, etc.).
5. I give permission for the medication(s) to be given by school personnel as delegated, trained and supervised by the school nurse.
6. I give permission for the school nurse to communicate, as needed, with the school staff about my child's medical condition(s) and the action of the medication(s).
7. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by medication(s).
8. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.
9. Legally, you may refuse to sign for the medication. If you refuse to sign, we will not be able to administer the medication at school.
10. This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

[ ] Yes [ ] No If this authorization is for Acetaminophen (Tylenol), I give permission for my child to take this medication from the schools' supply. (If no is checked, parents/guardians will need to supply the medication in an original container.)

\_\_\_\_\_  
Parent/Guardian Signature      Date      Relationship to Student

Return to: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
*Licensed School Nurse, RN*