(Form is **only** needed if your child will be taking medication at school)

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED AND SIGNED BY THE PHYSICIAN IF IT IS NECESSARY TO DISPENSE MEDICATION DURING SCHOOL HOURS

NAME OF MEDICATION	DOSAGE	METHOD OF ADMINISTRATION	TIME OF DAY TO BE TAKEN
_____	_____	_____	_____

If pm (as needed) specify the length of time between doses: _____
Reason for medication to given during school hours: _____
Permission to carry inhaler: 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 medication in accordance with the instructions indicated above from _____ to _____. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel.

_____ _____
Date of Signature Signature: Physician, Physician's Assistant, Dentist, Advanced Registered Nurse Practitioner

_____ _____
Telephone Number Name (Please print or type)

_____
Address

*Physician's Assistants (PR) may prescribe Schedule II-V drugs, however, the PA's supervising physician shall counter-sign on the patient's order or review and countersign the authorization and submit it to the school district within 30 days of the date of the order.

THIS PORTION OF THE FORM IS TO BE COMPLETED BY THE PARENT/GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to administer the above identified medication to the above identified student In accordance with the prescription or doctors instructions from _____ to _____ (not to exceed one school year.)

Medication will be supplied to the school in the original container by the parent/guardian.

I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed. Permission to carry inhaler: YES _____NO ___ as prescribed above.

Signature: _____ Date: _____