PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

Name of student: _____ DOB: _____

Diagnosis: _____

A. To be completed by physician:

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

MEDICATION	DOSAGE	FREQUENCY/ TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

DURATION OF TREATMENT: ☐ **20___/20____school year (including any summer sessions)**

☐ Other _____

Please note: medications and treatments will not be administered on early release days, with the exception of emergency medications, procedures and treatments.

Possible Side Effects and Adverse Reactions (if any): _____

PLEASE CHECK ONE:

__ I deem this child to be **NON SELF –DIRECTED** and understand that administration of oral, topical, inhalant, and injectable medication must remain the responsibility of the school nurse.

__I deem this child to be **SELF-DIRECTED** and understand that the school nurse, or other designated person in case of absence of the school nurse (**including field trips**) will supervise administration of medication

__I deem this child may **SELF-ADMINISTER** and **SELF-CARRY** their own medication with approval of the school nurse.

Physician Signature: _____ Date: _____

Address: _____ Phone: _____

Please note: The school nurse will assess the child's ability to be considered self-directed and/ or able to self- administer/carry their medications. The school nurse is responsible for making the final determination of self-direction and/or the ability to self-administer/carry medications.

B. To be completed by the parent/guardian:

I have consulted with my child's physician and agree with his/her recommendations. I request that my child receive the medication as prescribed above by our physician. The medication is to be furnished by me in the properly labeled container from the pharmacy.

Parent/guardian signature: _____ Date: _____

Telephone: Home: _____ Cell: _____ Work: _____

***Medication must be in original pharmacy labeled container with specific orders and name of medication.**

***Medication and refills must be brought to school by parent/guardian or responsible adult.**