AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT PIONEER SCHOOL DISTRICT

Student's Name ____ Birthdate ________________

Home Room Teacher __________________________________ Grade ____________________

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

NAME OF MEDICATION	DOSAGE	METHODS OF ADMINISTRATION	TIME OF DAY TO BE TAKEN
______________________	_____________	_______________________	________________

If prn - specify the length of **time between doses**: ________________________________

Reason for medication to be given during school hours: ________________________________

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Permission to carry (circle) **Inhaler: YES** ___ **NO** ___; **EpiPen: YES** ___ **NO** ___ ;
Insulin: YES ___ **NO** ___ (insulin injection may not be delegated to unlicensed staff)

Possible **side effects** of medication: ____

Emergency procedure in case of serious side effects: ____________________________________

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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 trained school personnel.

____________________ ____

Date of Signature Licensed Health Professional

____________________ ________________ ____

Telephone Number Fax Name (Please Print or Type)

____

Address City Zip code

THIS PORTION TO BE COMPLETED AND SIGNED BY THE PARENT/GUARDIAN.

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or instructions from a licensed health professional.

MEDICATION MUST BE SUPPLIED TO THE SCHOOL IN THE ORIGINAL CONTAINER; AND THE WRITTEN AUTHORIZATION MUST MATCH EXACTLY THE INFORMATION ON THE CONTAINER.

I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed. Permission granted to exchange medication information with the nurse.

_______________ ____________________________ _______________ _______________

Date of Signature Signature Home Phone Work Phone

REVIEWED BY ________________________________ (SCHOOL NURSE) DATE _______________

08/29/2022