

MEDICATION ADMINISTRATION AUTHORIZATION

STUDENT: _____ **SCHOOL:** _____ **GRADE:** _____

KNOWN ALLERGIES: _____

Medication: _____ Dose: _____ Time: _____

Route: Oral Inhalant Insulin Injection Nasogastric Tube Gastrostomy Tube

Other _____ Refrigeration needed: YES NO

Is this child qualified & able to self-administer this medication? YES NO

Does this child need to have this medication in his/her possession? YES NO

Reason for medication: _____

Potential adverse side effects: _____

Expected effects on learning: _____

PARENT/GUARDIAN AUTHORIZATION: *The school authorized personnel has my permission to administer the above medication. I will also adhere to the following conditions of this agreement:*

1. I will bring this form into the office completed and signed by my health practitioner before expecting medication to be administered;
2. I will bring the medication to school in its original pharmacy-labeled container (or manufacturer's container if over-the-counter), and I will maintain the supplies as needed throughout the year, or until discontinued;
3. I will renew this authorization every time there is a change of any kind regarding the medication, the information on this form, and/or the pharmacy label.
4. I will pick up the unused medication when it has been discontinued, and at the end of the school year. If I do not pick it up within 5 days I will allow the authorized personnel to dispose of it.

Parent/Guardian Signature: _____ **Date:** _____

Home Phone: _____ **Emergency Phone:** _____

PRESCRIBING PRACTITIONER AUTHORIZATION: *I have determined that the above described medications and routes of administration are medically necessary during school hours to maintain this child's physical health.*

Comments:

Practitioner Signature: _____ **Date:** _____

Office Phone: _____ **Fax Number:** _____