# AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ . Grade: _____

## THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER (LHCP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY
### (Please COMPLETE ALL AREAS)

| Name of Medication | Dosage | Method of Administration | Time to Be Taken |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Diagnosis or reason for medication: _____

**If given PRN, specify the length of time between doses:** _____

**I request and authorize this student to carry their (Non-scheduled) medication.** _____Yes _____ No

**I request and authorize this student to self-administer their (Non-scheduled) medication.** _____Yes _____ No

In agreeing that this student may self-administer medication, I concur that this student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

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 _____ (date) to _____ (date) **(not to exceed current school year)** as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____    _____
Licensed Health Care Provider (LHCP)         Date of Signature

_____    _____
Name **(please print)**                             Telephone Number

## THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request this medication to be given as ordered by the Licensed Health Care Provider. The medication is to be furnished by me in the original container and **brought to school by an adult.** Prescription medications must be labeled with the name of the student, medication, dosage, time of day to be given and the name of the prescribing health care provider. Over-the-counter medication must be labeled in the same manner.
- Any change in medication or dose or time must be handled as a new medication, and a new form completed by both the parent and health care provider.
- I understand that oral medications may be administered by non-licensed staff members who have been trained and are supervised by the Registered Nurse/ School Nurse.
- Written requests and authorizations must be renewed each school year.

I request and authorize my child to carry their medication. _____ Yes _____ No
I request and authorize my child to self-administer their medication. _____ Yes _____ No

_____    _____
Parent/Guardian Signature                        Date of Signature

Telephone Numbers: _____(home) _____(work) _____(cell)

Registered Nurse Reviewed: