## AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: $\qquad$ Birthdate:
School: $\qquad$ Gr: $\qquad$
THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/HEALTH CARE PROVIDER
Name of Medication Dosage Method of Administration Time of Day to Be Taken

If given "prn" specify the length of time between doses: $\qquad$
Diagnosis and reason for medication to be given during school hours: $\qquad$
Anticipated action: $\qquad$
Possible side effects of medication: $\qquad$
Emergency Procedure in case of serious side effects: $\qquad$
Student may carry and/or self-administer this medication during school hours: $\qquad$ Yes $\qquad$ No
(A backup supply of the same medication must be provided by the parents and stored with other medications at school. Medications considered to be controlled substances under federal law may not be carried and self-administered by a student under any circumstances.)

> ANY ELEMENTARY STUDENT WHO NEEDS TO CARRY AND/OR SELF-ADMINISTER MEDICATION MUST HAVE SCHOOL NURSE, HEALTH CARE PROVIDER AND PARENT PERMISSION AND AN EXCEPTION FORM ON FILE

I request and authorize the school to administer the above medication in accordance with the instructions indicated above from $\qquad$ to $\qquad$ not to exceed current school year.

Health Care Provider Signature: $\qquad$ Date: $\qquad$
Name: $\qquad$ Telephone: $\qquad$ (Print or Type)
Address:

## THIS PORTION 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. I request and authorize the school to administer this medication, during school hours only in accordance with the health care provider instructions indicated above.

MEDICATION WILL BE SUPPLIED TO THE SCHOOL IN THE PROPERLY LABELED ORIGINAL CONTAINER.
I give the health care provider permission to FAX this form to the school nurse: Yes $\square$ No $\square$
$\qquad$ Date: $\qquad$

Telephone: $\qquad$ (Home)

