AUTHORIZATION OF STUDENT MEDICATION

To: The Principal of _____School Date_____

I, the parent/guardian of _____, D.O.B.____/____/____, would like to request that medication be given to my child at school according to the directions specified below by my family doctor. I also release any and/or all school personnel from any liability that could be brought about by administering this medication as requested here by our doctor.

Parent/Guardian_____ _____ _____
(please print parent name) (parent signature)

****

In accordance with the request of the parent whose name is listed above, I request the following medication be given to _____by school personnel at school during regular school hours.

Diagnosis	Medication to Be Given	Dosage(mg)	Time to be Given
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

Doctor's Initials

Yes	No	
___	___	Would this medication be dangerous if taken by any person other than the one for whom it was prescribed?
___	___	Should this medication be kept in a locked container?
___	___	Does this medication require storage under refrigeration?
___	___	Would this medication prevent the child from participation in field trips or other school activities?
___	___	Is any of this medication specifically for seizure control?
___	___	Do you recommend any of the following medications be carried by this person at all times? (With this physician recommendation, only these medications may be carried by a student: Asthma inhalers, Epi Pens, Diabetic insulin to be taken by an insulin pen or self-administered by a syringe injection. All students that self administer insulin must provide own sharps receptacle. A health plan must be in place to administer insulin.)

Any specific instructions to the school:_____

_____ _____ _____
Doctor's Name (please print) Doctor's Signature Phone Number

****

_____ _____ _____ _____
Signature of Principal Date Signature of School Nurse Date

_____ _____
Signature of School Person to give medication Date School Person trained by School Nurse

_____ _____
Signature of Alternate School Person to give medication Date Alternate School Person trained by School Nurse

THIS AUTHORIZATION IS IN EFFECT FOR THIS SCHOOL YEAR
A NEW FORM MUST BE SIGNED BY THE DOCTOR EACH YEAR

AcroPDF - A Quality PDF Writer and PDF Converter to create PDF files. To remove the line, buy a license.