



## Authorization for Administration of Medication at School

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

### This Portion to Be Completed By the Licensed Health Professional

Name of Medication	Dosage	Method of Administration	Time(s) to Be Taken
_____	_____	_____	_____

Diagnosis or reason for medication: \_\_\_\_\_

If given PRN, specify the minimum length of time between doses and when to administer: \_\_\_\_\_

May the student carry this medication on his/her person and self-administer? \_\_\_\_\_ Yes\* \_\_\_\_\_ No

\* Student has demonstrated to licensed health professional the ability to correctly administer this medication.

Student under 12 years may be permitted to carry and self-administer a metered dose inhaler and/or emergency medication for a predetermined, life-endangering situation (Monroe Public Schools Board Policy 5432).

Possible side effects of medication: \_\_\_\_\_

Emergency procedure in case of serious side effects: \_\_\_\_\_

I request and authorize 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). There exists a valid health reason which may make administration of the medication advisable during school hours.

\_\_\_\_\_  
Licensed Health Professional Signature Date

\_\_\_\_\_  
Name (please print) Phone Fax

### This Portion to Be Completed By the Parent/Guardian

- I request this medication be given as ordered by the licensed health professional.
- I give Health Services Staff permission to communicate with the medical office about this medication. I understand oral medications may be administered by non-licensed staff members who have been trained and are supervised by a Registered Nurse.
- Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must be brought to school in its original container with instructions as noted above by the licensed health professional.

I request and authorize my child to carry and/or self-administer his/her medication. \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Parent/Guardian Signature Date

Telephone #: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Reviewed by Registered Nurse: \_\_\_\_\_ Date: \_\_\_\_\_