Authorization for Administration of Medication at School

(Writable PDF)

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

* If a health professional and a student's parent request that a student be permitted to carry his/or her own medication and/or be permitted to self-administer the medication, the principal may grant permission after consulting with the school nurse. The process for requesting and providing instructions will be the same as established for oral medications. The principal and nurse will take into account the age, maturity and capability of the student; the nature of the medication; the circumstances under which the student will or may have to self-administer the medication and other issues relevant in the specific case before authorizing a student to carry and/or self-administer medication at school (BP:3416P).

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: _____

BP:3461P
Health Services
081722
www

This authorization is valid for the current school year only