Medication Authorization Form

Date: _____ School Year: _____

Student Name: _____ School: _____ DOB: _____ Grade: _____

To be completed by Healthcare Provider:

This order can only be signed by Physician (MD, DO), Dentist, Nurse Practitioner (NP, FNP, PNP, APRN), or Certified Physician's Assistant. Please provide **ONE** medication per form.

Diagnosis: _____

Medication: _____

☐ Routine – Dose*: _____ Time: _____ Route: _____

☐ PRN – Dose*: _____ How Often: _____ Route: _____

Please specify mg, mcg, ml, puffs, etc.

Reportable Adverse Reactions/Side Effects: _____

_____

Medication Self- Administration Authorization: ☐ Yes ☐ No

The above named student is under my care. I feel it is medically appropriate and the student is trained and capable to carry and self-administer the following indicated medication at all times:

☐ Inhaler ☐ Insulin Pen ☐ Epi-Pen/Auvi-Q

Name of Healthcare Provider: _____ Phone: _____

Healthcare Provider Signature: _____ Date: _____

Parental Responsibilities:

- I have administered at least one dose of this medication to my child without adverse effects.
- The medication is to be furnished by the parent and brought to the school in the current original container, labeled with the child's name, medication name, time, dosage, and healthcare provider's name.
- All medications must be delivered to the school by an adult and picked up by an adult within two weeks of last dose given.
- I understand a new medication authorization form will be required each school year, and any time there is a dosage change.

I understand that by signing this form I am giving permission to the school nurse to contact the healthcare provider if clarification is needed for administering the medication listed above. I am willing to meet parental responsibilities. School will administer only the medication listed above.

Parent Signature: _____ Date: _____

Emergency Contact: _____ Phone Number: _____

Secondary Emer. Contact: _____ Phone Number: _____