



AUTHORIZATION FOR MEDICATION TO BE TAKEN AT SCHOOL

THE FOLLOWING SECTION IS TO BE COMPLETED BY A PARENT/GUARDIAN:

STUDENT NAME: LEGAL LAST NAME		LEGAL FIRST NAME		GENDER:	BIRTH DATE:
SCHOOL:	FAX:	GRADE:	TEACHER:		
HEALTH CARE PROVIDER'S NAME:		PHONE:		FAX:	
<p>I request that authorized persons help my child take the medicine(s) described below at school or that my child be permitted to medicate themselves/carry medicines as authorized by me and my prescribing health care provider (see below). I give my permission for exchange of information between the school district and the health care provider. I acknowledge that the district shall incur no liability as a result of any injury arising from the district's administration of oral medications in substantial compliance with the prescription.</p>					
PARENT/GUARDIAN/STUDENT SIGNATURE:					DATE:
HOME PHONE:			EMERGENCY PHONE:		

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

DIAGNOSIS:	MEDICATION:	DOSE:	TIME:	ROUTE:	FREQUENCY:	AUTHORIZED TO SELF-ADMINISTER <input type="checkbox"/> *YES <input type="checkbox"/> NO
SIDE EFFECTS:						
DIAGNOSIS:	MEDICATION:	DOSE:	TIME:	ROUTE:	FREQUENCY:	AUTHORIZED TO SELF-ADMINISTER <input type="checkbox"/> *YES <input type="checkbox"/> NO
SIDE EFFECTS:						
DIAGNOSIS:	MEDICATION:	DOSE:	TIME:	ROUTE:	FREQUENCY:	AUTHORIZED TO SELF-ADMINISTER <input type="checkbox"/> *YES <input type="checkbox"/> NO
SIDE EFFECTS:						
DIAGNOSIS:	MEDICATION:	DOSE:	TIME:	ROUTE:	FREQUENCY:	AUTHORIZED TO SELF-ADMINISTER <input type="checkbox"/> *YES <input type="checkbox"/> NO
SIDE EFFECTS:						
Length of time this medication is needed: ___ / ___ /20 through ___ / ___ /20					Entire current school year: 20_____	
<p>If I have checked "yes" above, I verify that the student has demonstrated to me the skill level necessary to use the medication and the device necessary to administer the medication.</p>						
HEALTH CARE PROVIDER SIGNATURE:						DATE:
HEALTH CARE PROVIDER ADDRESS:						

THE FOLLOWING SECTION IS TO BE COMPLETED BY SCHOOL:

NURSE SIGNATURE:		DATE:
SELF-ADMINISTER <input type="checkbox"/> *YES <input type="checkbox"/> NO	REVIEWED BY NURSE AND OKAY TO GIVE MEDS:	MEDS ENTERED INTO SKYWARD: DATE: _____ INITIAL: _____