AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

SECTION 1: TO BE COMPLETED BY PARENT OR GUARDIAN

Student Name: _____ DOB: _____

School: _____ Grade: _____

I request/authorize the school to administer medication in accordance with the doctor's instructions for the period from _____ to _____ (not to exceed the current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner. Due to staff and school schedules and other responsibilities it is permissible for a dose or dosages to be delayed or missed.

Permission to carry inhaler: ☐ Yes ☐ No

Permission to self-administer medication: ☐ Yes ☐ No

MEDICATION MUST BE SUPPLIED IN THE ORIGINAL, LABELED CONTAINER

Date: _____ Signature: _____

Phone: _____ (Home) _____ (Work) _____ (Celular)

SECTION 2: TO BE COMPLETED BY THE PHYSICIAN

NAME OF MEDICATION	DOSAGE	METHOD OF ADMINISTRATION	TIME OF DAY TO BE TAKEN
_____	_____	_____	_____
_____	_____	_____	_____

Diagnosis which requires medication at school: _____

If given prn, specify length of time between doses: _____

Inhalers: _____
(Indicate if student must carry on hes/her person.)

Student is capable of self-administration of medication: ☐ Yes ☐ No

Anticipated action: _____

Possible side effects of medication: _____

Emergency procedures in case of serious side effects: _____

I request and authorize that the above named student be administered the above identified medication in accordance with the above instructions from _____ to _____ (not to exceed the current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours. Such medication may be administered by medically untrained school personnel.

_____
Date of Signature

_____
Physician Signature

_____
Physician Phone Number

_____
Please Print Physician's Name

_____
Physician Address