



**AUTHORIZATION TO ADMINISTER MEDICATION
(For Non-Asthma Medications)**

Many children are able to attend school because of the effectiveness of medications in the treatment of many chronic disabilities and long and short-term illnesses. If possible, all medications should be given at home. However, if your child's physician decides it is necessary for your child to receive a medication during the school day, the approval and specific directions must be provided to the school. It is recommended that the first dose of medication be administered at home. Note: A separate form is required for each medication and a new form must be completed for any change in dose, time or method of administration. The 'Authorization to Administer Medication' form is valid for the current school year only.

For medication to be safely administered at school every item on this form must be completed.

Student's Name _____ DOB _____

School Year: _____ Teacher _____ Grade _____

PHYSICIAN'S STATEMENT

1. I have examined this student for (diagnosis) _____ on (date) _____ and have determined that he/she requires medication during school hours.
2. **Name of Medication** _____ **Dose** _____
Route _____ **Time of Administration** _____ **Duration** _____
3. In the event the morning dose is not given at home, the following may be administered on a PRN basis: _____
4. Side effects that may be experienced _____
5. Please contact me if the following signs or symptoms appear _____

Physician's Name (print) Physician's Signature

Date Phone Number Office Fax Number

PARENT/GUARDIAN STATEMENT

1. I/We the undersigned parent(s)/guardian(s) of the above named student hereby request the school nurse (or designee) to administer and/or supervise self administration of the above medication according to the physician's instructions.
2. I/We agree to furnish the necessary prescribed medication in the properly labeled container, to provide replacement medication as necessary and to notify the school nurse immediately if the physician or medication prescription is changed.
3. I/We authorize, as needed, the sharing of information related to my child's health between the school nurse (and designee) and the health care provided listed on this form.

Parent's/Guardian's Name (print) Parent's/Guardian's Signature

Date Home Phone Number Work Phone Number Cell Phone Number

THE DISTRICT (INCLUDING ITS EMPLOYEES AND AGENTS) SHALL NOT INCUR ANY LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE STUDENT'S TRANSPORT OR SELF-ADMINISTRATION OF MEDICATION, AND THE PARENT/GUARDIAN SHALL INDEMNIFY AND HOLD HARMLESS THE DISTRICT (INCLUDING ITS EMPLOYEES AND AGENTS) AGAINST ANY CLAIMS ARISING OUT OF THE TRANSPORT AND SELF-ADMINISTRATION OF MEDICATION.

Medication Expiration Date: _____
For Office Use Only