

**Finley School District  
Authorization for Administration  
Of Medication at School**

**Elem. School Phone: 586-7577 Fax: 586-8239  
Middle School Phone: 586-7561 Fax: 582-8452  
High School Phone: 582-2158 Fax: 586-9297**

Student Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

School: \_\_\_\_\_

Grade: \_\_\_\_\_

**THIS PORTION TO BE COMPLETED BY THE PRIMARY CARE PROVIDER ONLY**

Name of Medication	Dosage	Methods of Administration	Time of Day to Be Taken
_____	_____	_____	_____

If given as needed, specify the length of time between doses \_\_\_\_\_

Reason for medication to be given at school: \_\_\_\_\_

Anticipated action: \_\_\_\_\_

**Is this condition considered life-threatening? Yes\_\_ No\_\_**

Indicate if student may carry Inhaler or Epi-pen on his/her person: Yes \_\_ No \_\_

Student is capable to self-administer medication: Yes \_\_ No \_\_

Possible side effects of medication \_\_\_\_\_

Emergency procedure in case of serious side effects \_\_\_\_\_

I request and authorize that the above-named student be administered or self-administer the above identified medication in accordance with the instructions indicated above from

\_\_\_\_\_ to \_\_\_\_\_ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Primary Care Provider's Signature

\_\_\_\_\_  
Telephone Number (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
Name

Print or type

**Please note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.**

**Parent/Guardian to Complete**

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period \_\_\_\_\_ to \_\_\_\_\_ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner. I understand the nurse may communicate with the above provider concerning this order. **If I have given permission for my child to carry and self-administer above medications, I acknowledge I have read and agree with Procedure No 3419 (Self-Administration of Asthma and Anaphylaxis Medications), see reverse side.**

Permission to carry inhaler or Epi-pen \_\_\_\_\_ Yes \_\_\_\_\_ No

Permission to self-administer medication \_\_\_\_\_ Yes \_\_\_\_\_ No

On early release days, I request my child be given his/her medication: \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Parent/Guardian Signature

**Telephone number:** (\_\_\_\_) \_\_\_\_\_ (home) (\_\_\_\_) \_\_\_\_\_ (cell) (\_\_\_\_) \_\_\_\_\_ (work)