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

Authorization for Administration of Medication at School

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 Insulin Pen or 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)