**Authorization for Administration of Medication at School**

Name of Student: Birthdate: **\_\_\_\_\_\_\_\_\_\_\_**

School: School Year:

| Medical Condition  ICD-10 Code | Medication | Strength | Dose | Time | Route | Possible Side Effects |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Other Considerations/Directions:

Start Date: Stop Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ (All authorizations expire at the end of ESY)

□ Student is knowledgeable about the medication and how to administer it.

□ Student has the skills to safely possess and use an inhaler.

□ Student may self-administer the medication. (Not applicable for controlled substances.)

Print/Type Name of Physician/Licensed Prescriber Physician’s / Licensed Prescriber’s Signature

Clinic Address Phone Number Date

**Parent/Guardian Authorization**

1. I request that the above medication(s) be given during school hours as ordered by this student’s physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify the school of any change in the medication(s). (ex: dosage change, medication is discontinued, etc.)
4. I give permission for the school nurse to communicate with the student’s teachers about the student’s health condition(s) and the action of the medication(s).
5. I give permission for the school nurse to consult with the above named student’s physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s)
6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
7. I give permission for a photo of my child to be uploaded into Infinite Campus to be used for medication administration purposes

□ My son/daughter may self-administer his/her medication. (Not applicable for controlled substances, such as Ritalin, Dexedrine, Codeine, etc.)

Date Parent/Guardian Signature Relationship to Student