# AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION

Student Name _____

ID #_____DOB _____Grade/School year_____

***This order is valid for school year (current) _____ including summer session***

## ***LICENSED PRESCRIBER AUTHORIZATION***

| | | |
|---|---|---|
| Condition for which medication is being administered: | | |
| Allergies: | | |
| Medication: | Dose: | Route: |
| Time of administration:_____ *OR* ☐Breakfast ☐Lunch | If PRN, frequency: | |
| Relevant side effects: ☐ None expected ☐ Specify: | | |
| Other medications student is receiving: | | |
| Time interval for re-evaluation: | | |

| | | |
|---|---|---|
| Licensed Prescriber's Name/Title (please print) | | |
| Address | Phone | Fax |
| Licensed Prescriber's Signature | | Date |

## ***PARENT/GUARDIAN AUTHORIZATION***

- I request designated staff to administer the medication as prescribed by the licensed provider above.
- I certify that I have legal authority to consent to the administration of medication at school.
- I authorize the school nurse to communicate with the licensed prescriber regarding the administration of this medication.

| | | |
|---|---|---|
| Parent/Guardian Signature | | Date |
| Home phone | Work Phone | Cell Phone |

## ***DISCONTINUATION/HOLD CONFIRMATION OF MEDICATION FROM PRESCRIBER***

| | |
|---|---|
| *Confirmed by:* | *Date Confirmed:* |