

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: _____ <i>OR</i> <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch	If PRN, frequency:	
Relevant side effects: <input type="checkbox"/> None expected <input type="checkbox"/> 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

<ul style="list-style-type: none"> ▪ 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:
---------------	-----------------