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 and appropriate staff 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:*