

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____
School: _____ Grade: _____

**THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP)
PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY**

<u>Name of Medication</u>	<u>Dosage</u>	<u>Methods of Administration</u>	<u>Time of Day To Be Taken</u>
_____	_____	_____	_____
_____	_____	_____	_____

Diagnosis or reason for medication: _____

If given PRN, specify the length of time between doses: _____

Inhalers: _____
Indicate if student carry on his/her person

Student is capable of self-administration of 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 the above identified oral medication in accordance with the instructions indicated above from _____ (date) to _____ (date) (not to exceed current school year) as there exists a valid health reason which make administration of the medication advisable during school hours.

Date of Signature Licensed Health Professional

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.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the LHP's instructions for the period from _____ 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.

Permission to carry inhaler _____ Yes _____ No

Permission to self-administer medication _____ Yes _____ No

Date of Signature Parent/Guardian Signature

Telephone Number: _____ (home) _____ (work)