# AUTHORIZATION FOR ADMISTRATION OF MEDICATION AT SCHOOL

## THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

Students Name____________________________________________Birthdate________________________________

School___________________________________Teacher________________________Grade_____________________

Physician's Name___________________________________Physician's Phone_________________________________

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to administer the prescribed medication to the above identified student in accordance with the prescription of doctor's instructions. **Medication must be supplied to the school in the original container and must be transported by parent or guardian.**

Parent/Guardian Signature____________________________________________________________________________

Home Phone____________________________Emergency Phone___________________________________________

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## THIS PORTION TO BE COMPLETED BY THE PHYSICIAN

NAME OF MEDICATION STRENGTH/DOSAGE METHOD OF ADMINSTRATION TIME TO BE TAKEN

_______________________ _________________________________________________________________________

Diagnosis for which medication is given:_______________________________________________________________

Anticipated action:__________________________________________________________________________________

Possible side effects of medication___________________________________________________________________

Emergency procedures in case of serious side effects:____________________________________________________
**Inhaler Use**:

☐ Student has been instructed in the correct and responsible use of medication to treat asthma.

Recommendation: A prescription for a backup inhaler to store at school and spacer be provided to parent/guardian.

I request and authorize that the above name student be administered the above identified medication in accordance with the instructions indicated above for the period ______________to _____________ (not be exceed current school year) as there exists a valid health reason which makes administration of the medication necessary during school hours or during such time that the student is under supervision of school officials. School personnel that are not medically trained may administer such medication.

________________________________________________________________ ________________________________
Physician's/Dentist's Signature Date of Signature

_________________________________________ _________________ _____________________________________
Name (Print or Type) Telephone Number Address