Medication Authorization for 2020-2021
For Oral, Drops, Topical and Emergency Injected Medication Administration at School

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

LICENSED HEALTH PROFESSIONAL (LHP)
Complete this section using one form for each medication

Diagnosis or reason for medication: _____

Severity of the problem: ❑ **mild** ❑ **moderate** ❑ **severe**
Activity modifications or restrictions:

_____

Name of Medication	Dosage	Method of administration	Time to be given or frequency if PRN

If given PRN, describe indications: _____

For EpiPens, describe signs or symptoms when to use:

_____

Can the student travel on field trips > 30 minutes away from emergency medical response?

❑ **Yes** ❑**No**

Possible side effects of medication:_____

Student is capable of self-administration of medication and has received instruction in the correct and responsible way to use the medication: ❑ **Yes** ❑ **No**
Student can carry the medication on their person responsibly: ❑ **Yes** ❑ **No**

I request and authorize that the above-named student be administered or self-administer this oral medication according to the instructions indicated above from 08/2021 to 06/2022 (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____
Date of Signature ***Licensed Health Professional***

_____/_____ _____
Phone ***FAX*** ***Name (Print)***

PARENT or GUARDIAN: To complete this section

I request and authorize the school to administer medication to the above student in accordance with the LHP's instructions for the period from 08/2021 to 06/2021 (not to exceed the current school year).

I understand that information about this medication and health problem will be shared with school staff that need to know.

My child can carry and self-administer this medication at school

❑ **Yes** ❑ **No**

If I give permission for my child to carry and self-administration medication, I understand and agree that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the student.

_____ _____

Date of Signature ***Parent/Guardian Signature***

Reviewed by School Nurse: _____ ***Date:*** _____