PARENT AND HEALTH CARE PROVIDER AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by the parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy.* I understand that the school nurse will administer the medication or a designated adult, in the case of the absence of the school nurse, will supervise my child taking his/her own medication, including field trips.

_____

Parent/Guardian signature Date

B. To be completed by the licensed health care provider (HCP):

I hereby request that my patient _____, _____,
Student's name Date of Birth

be administered _____ _____
Name of Medication Dosage

_____ _____ _____
Route of Administration Frequency Time to be given at school

DIAGNOSIS: _____

Possible Side Effects and Adverse Reactions (if any): _____

_____

Other Recommendation: _____

_____

_____

Health Care Provider's Name and Title (please print) signature

_____

HCP address HCP phone number

*Medication must be in original pharmacy labeled container with specific orders and name of medication. Medication and refills must be brought to school by parent, guardian or responsible adult.