EASTMONT SCHOOL DISTRICT – Health Services

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name ______________________________ Birth date ________________

School ______________________________ Grade ________________

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

NAME OF MEDICATION	DOSAGE	METHODS OF ADMINISTRATION	TIME OF DAY TO BE TAKEN
________________	______	____________	__________
________________	______	____________	__________

Diagnosis or reason for medication: ____

Possible side effects of medication ____

Emergency procedure in case of serious side effects ______________________________

Student may carry inhaler: __________ Yes __________ No

Student is capable of self-administration of medication: __________ Yes __________ No

I authorize and request that the above-named student be administered the above identified 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 makes administration of the medication advisable during school hours.**

____________________ Date of Signature

____________________ Physician's/Dentist's Signature
(We recommend that PA orders be countersigned by the supervising physician.)

Telephone ____________________ Name ______________________________

Address ______________________________

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 Licensed Health Professional's (LHP's) instructions for the period from ______________ to ______________. (Not to exceed the current school year) I understand that every effort will be made by school staff to administer the medication in a timely manner.

If Physician & School Nurse gives permission to self carry inhaler or self-administer medication: Do you give authorization for your child to:

Carry inhaler __________ Yes __________ No

Self-administer medication __________ Yes __________ No______________

Signature ______________________________
(Date of Signature)

Telephone ____________________ / ____________________
(Home) (Work)