Hanover Public Schools **Health Services**

Authorization for Medication Administration in School

Part 1:
To be completed by a licensed prescriber: physician, nurse practitioner or other authorized provider

Name of student: _____ Grade: _____

Student Mobile Phone Number: _____

Date of birth: _____ Sex: _____ Weight: _____

Medical History/Diagnosis: _____

Allergies: _____

Printed name of licensed prescriber: _____ Title: _____

Tel. No. (office): _____ Tel. No. (emergency) _____

This order is valid for school year of : 20 ___ - 20 ____

Date of order: _____ Discontinue date (if not the entire school year): _____

Name of Medication: _____

Dose: _____ **Route of Administration: _____**

Frequency: _____ **Time(s) of Administration: _____**

Additional directions:_____

Prescriber signature: _____

_____

Part 2: To be completed by parent or guardian

Parent/Guardian Name: _____ Emergency Contact: _____

Address: _____

Please list all medication the student takes at school and/or at home:

_____

_____

Please list all of the child's known medication allergies: _____

I, _____ (*print name of parent/guardian*), give permission for the school nurse to administer _____ (*print name of medication)* to my child, _____ (*print name of student*) as ordered by the licenced prescriber above. I also give the school nurse permission to share this information with appropriate school and emergency personnel as needed to serve safety and educational needs.

Student may self-administer this medication with permission of the school nurse:

Yes ____ No ____

Signed: _____ Date: _____

signature of parent/guardian

Reviewed by school nurse: _____ _____ Date: _____

Printed nurse's name *Nurses signature*