



**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: \_\_\_\_\_

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*