PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child_____ DOB_____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.*

Signature (Parent or Guardian):_____ Date_____

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Medication	Dosage	Frequency/Time to be taken	Route of administration

Diagnosis: _____Duration of treatment_____

Possible Side Effects and Adverse Reactions if any:_____

PLEASE CHECK ONE:

- ❑ I deem this child to be self -directed and understand that the school nurse or other designated person in case of the absence of the school nurse, will administer the medication, including field trips.
- ❑ I deem this child to be non self-directed and understand that administration of oral topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

---For Albuterol orders ONLY—

- ❑ I give permission for the school nurse to administer the school's stock of Albuterol as above, **temporarily, in the event the above child's prescription is empty, awaiting refill.** (Please disregard if child does not use an inhaler or nebulizer.)

Physician's Signature _____ Date_____

Address_____ Phone_____

** 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.

Plan reviewed with parent(s)/guardian(s):

Parent Signature:_____ Date:_____