

School District: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL**

**Prescriber's Authorization**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Condition for which drug is being administered: \_\_\_\_\_

Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time of Administration: \_\_\_\_\_ If PRN, frequency: \_\_\_\_\_

Relevant side effects: ☐ None expected ☐ Specify: \_\_\_\_\_

ALLERGIES: ☐ NO ☐ YES (specify): \_\_\_\_\_

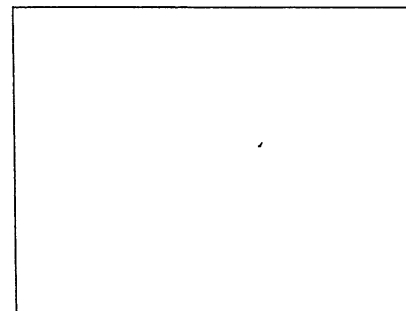
Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: \_\_\_\_\_  
(Type or print)

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Use for Prescriber's Stamp

**PARENT/GUARDIAN AUTHORIZATION**

*I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a 45 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

**SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL**

*Self administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse in accordance with Board policy.*

Prescriber's authorization for self administration: ☐ Yes ☐ No \_\_\_\_\_  
Signature Date

Parent/Guardian authorization for self administration: ☐ Yes ☐ No \_\_\_\_\_  
Signature Date

School nurse approval for self administration: ☐ Yes ☐ No \_\_\_\_\_  
Signature Date