Permission Forms for Medication

PHYSICIAN AUTHORIZATION FOR MEDICATION FORM

Student's Name: _____ Grade: _____ Age: _____ Date of Birth: _____/_____/_____

School: _____

COMPLETED BY THE PARENT/GUARDIAN AND HEALTH CARE PROVIDER

Procedure 09.2241 AP.1 – Medication shall be in the original container, dated upon receipt. Prescribed medication/self-administration/over-the-counter medication needed for longer than three (3) days requires a parent/guardian and Health Care Provider to complete the required form.

Name of Medication: _____ **Reason:** _____ **Stop date**: ___/___/___ or End of School Year **Time to be given:** _____ **Dose** _____**MG/ML/PUFFS/UNITS** **(please circle one)**	**Name of Medication:** _____ **Reason:** _____ **Stop date**: ___/___/___ or End of School Year **Time to be given:** _____ **Dose** _____**MG/ML/PUFFS/UNITS** **(please circle one)**
Signs and symptoms of emergency administration: _____ Restriction and/or important side effects: _____ ***** Student must self-carry medication on his/her person and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel.) ☐ Yes **(*MD to initial below)** ☐ No ***SPECIFIC TO FIELD TRIPS ONLY:*** *(*Please check 1 box) ☐ Trained personnel to assist student to self-medicate. (School personnel will hold medication until dosing time) ☐ ***** Student to self -carry and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel) **(*MD to initial below)** ☐ Student requires medication to be administered (School personnel will hold medication and administer)	Signs and symptoms of emergency administration: _____ Restriction and/or important side effects: _____ ***** Student must self-carry medication on his/her person and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel.) ☐ Yes **(*MD to initial below)** ☐ No ***SPECIFIC TO FIELD TRIPS ONLY:*** *(*Please check 1 box) ☐ Trained personnel to assist student to self-medicate. (School personnel will hold medication until dosing time) ☐ ***** Student to self -carry and may self-administer. (Student will hold medication on their person for self-administration or for immediate access of school trained personnel) **(*MD to initial below)** ☐ Student requires medication to be administered (School personnel will hold medication and administer)

PROVIDER SIGNATURE FOR ALL MEDICATIONS

_____ ___/___/___ Physician Practice name: _____
Physician/Health Care Provider Signature Date

Address: _____

Phone: (___) _____ Fax: (___) _____

***FOR SELF CARRYING/ SELF ADMINISTRATION ONLY**

_____***(MD INITIALS)** The above-named student has been instructed on the care, storage, dosage, and use (up to/and including getting help of trained personnel if student feels they are unable to administer the medication safely/effectively in an emergency situation) of the above medication(s) and has sufficient knowledge and ability to self-carry / self-administer the medication(s) in the school setting and while on field trips.

PARENT AUTHORIZATION FOR ABOVE LISTED MEDICATIONS

I give permission for _____ to receive the above medication(s) at school according to
Student's Name
standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ *Signature:* _____ *Relationship:* _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

I/we reviewed the statement and authorization for completion. ***Administrator/designee*** _____ Date ___/___/___