Medication Authorization Form School Year 2018-2019

Parent/guardian AND a licensed health care professional must provide written permission for school personnel to administer medications(s) every school year.

Student:	uanimister m	euicutions(s ·) every scho OR:	ool year.	C1		
PHYSICIAN/LICENSED PRO	VIDER - DIEACE COMBU	*****	· · · · · · · · · · · · · · · · · · ·		Grad	e:	
THE PROPERTY OF THE PROPERTY O							
All authorizations expire at	MEDICATIONS REd	QUIKED DUF	RING SCHO	OL HOURS		-	
All authorizations expire at Medication	Diagnosis/Reason	ar or followi	ng Extende				
Wiedledion	for Medication	ICD	Dose	Time	Route	Possible Side Effect	
	TOT Wiedication	10			ĺ		
L.		Code		 			
Name:							
		1	·				
haler—please include Asthma A	Action Plan:			<u> </u>	L		
☐ Student may carry/self a	dminister his/her inhaler acco	rding to the lic	ensed prescrib	er's instructio	ns This etm	dent has been instructed	
proper use, side effects,	and safeguards regarding this	medication.		oci o motractic	1115 Stu	uent has been instructed	
☐ It is my professional opin inephrine auto-injector—please	nion that this student should n	ot carry his/he	r inhaled med	lication.			
☐ Student may carry/self a	dminister eniperbring auto in	Plan:	****				
	dminister epinephrine auto-ir roper use, side effects, and sa				prescriber	's instructions. This stude	
C is my professional opin	ion that this student should n	ot carry his/he	r Epi-pen/auto	cation. n-injector			
☐ Student may carry/self ac	dminister				(Please ider	ntify).	
gnature of Licensed Health Care F	Drovidor B						
product of electrical fleater care r	Printed i	name of Licens	ed Health Care	e Provider	Dat	e	
nic Name/Address	Clinic Pl	Clinic Phone #		Clinia Face			
				Clinic Fax #			
rent/Guardian Medicati	ion Authorization				·····		
•							
I request the medication i	listed be given during sch	nool hours as	ordered by	this studen	t's license	ed health care	
provider. Only daily meal	cations and those for life	threatenina	lemeraenci	, conditions	will bo co	mt am field total	
I will provide the school w	ith physician/licensed or	escriber aut	horization f	or one of a	will be se	ncon jielu trips.	
treatment(s). (Example: d	losage change time char	aga discouti	nonzacion j	or any chan	ge in mea	ication(s) and/or	
I give permission to design	nated ash a late of the	ige, uisconti	nuea, etc.)				
I give permission to design	nateu striooi stajj to aan	ninister the c	ibove medic	cation(s) and	d/or perfo	orm treatment(s). I	
release the school personi	nei Jrom any liability in tl	he administr	ation of this	medication	alcl or tra	atma a m t	
i unuerstana that school	health staff cannot adm	inister the n	nedication(1/treatmen	t/cl/nroc	adrimata) implimitant	
ans joins without authori	ization from both my stu	ident's physi	ician/licens	ed nrescribi	or and au	ardian /n	
r give permission for near	n office staff to consult w	vith this stud	lent's licens	ed health co	ra provid	or romandin u	
questions about the above	e medical condition(s) an	d medicatio	n/nrocedure	haina uso	la anni	er regulating	
Provider name:	Cli	nic nama:	i) procedure	: Delity used	i to treat i	ne condition.	
Provider name: Fax:	C/I	rnc name:					
	ealth office ct-ff t-						
I give permission for the he	euitii Ojjice stajj to comn	nunicate as i	needed with	h school sta	ff about n	ou studout a bould	
condition(s) and the action	C + C + C		recued will	i scribor staj	ij ubbut ii	iy student s nealth	
	n of the medication and/	or treatment	:	r scribbi staj	ij ubout ii	iy student s nealth	
ent/Guardian Signature:	n of the medication and/o	or treatment	:.)ate·	ij ubout ii	iy student s nearth	