AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION AT SCHOOL

Student Name _____ *Date of Birth* _____

Program _____ *School Year* _____ *Grade* _____

PHYSICIAN/LICENSED PRESCRIBER'S ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL
Medical Diagnosis & ICD-10-CM Code MUST be completed by Physician/Licensed Prescriber

MEDICAL DIAGNOSIS	ICD-10-CM CODE	MEDICATION	DOSE	TIME	ROUTE	POSSIBLE SIDE EFFECTS
1.						
2.						

☐ Student is knowledgeable about the medication and how to administer it.
☐ Student has the skills to safely possess and use an inhaler.
☐ Student may self-administer the medication. (Not applicable for controlled substances.)

Other considerations/directions:

_____

_____

Start Date _____ Stop Date _____
(All authorizations expire at the end of the school year or following the summer school session.)

Signature of Physician/Licensed Prescriber _____ *Print Name of Physician/Licensed Prescriber* _____ *Date* _____

PARENT/GUARDIAN AUTHORIZATION

1. I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I will notify the school of any change in the medication(s), (i.e., dosage change, medication is stopped, etc.).
3. I give permission for the medication(s) to be given by school personnel as delegated, trained, and supervised by the school nurse.
4. Legally, I may refuse to sign for the medication. If I refuse to sign, school personnel (including the school nurse) will not be able to administer the medication at school.
5. This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

NOTE: MEDICATION MUST BE SUPPLIED IN ORIGINAL/PRESCRIPTION BOTTLE.

PERMISSION FOR RELEASE OF INFORMATION

6. I give permission for the school nurse to communicate as needed with school staff about my child's medical condition(s) and the action of the medication(s).
7. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by medication(s).
8. I give permission for the Physician/ Licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.

Parent/Guardian Signature _____ *Date* _____ *Relationship to Student* _____

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SOUTHWEST METRO INTERMEDIATE DISTRICT 288