Authorization for Administration of Medication

Academic school year: 2010-2011

Student's name Last First Birth date Date

Parent Authorization

Administration of medication is needed for my child during regular school hours

Parent/Guardian name (print) **Parent/Guardian signature**

Address: Street Emergency/home phone number

City/State/Zip Cell phone/business phone

Physician Authorization

Administration of medication is needed for this student during regular school hours

Disease/Syndrome/Condition Allergies

Medication/dosage/route Side effects, if any

Administration time(s) Discontinue / re-evaluation date(s)

Student is capable of self-administration of **Asthma/Diabetic/Allergic** medication YES NO

Student may carry/store the **Asthma/Diabetic/Allergic** medication on his/her person or in an area of easy access YES NO

Physician Name (print) **Physician Signature**

Address: Street **Physician phone number**

City/State/Zip Date

- **Medication administered at school following these guidelines:**
- **Completed, signed and dated *Authorization for Administration of Medication***
- **Medication is in the original, labeled container as dispensed or the manufacturer's labeled container.**
- **Medication label contains student's name, name of the medication, directions for use and date.**
- **Authorization for administration of medication renewed annually.**
- **Immediate notification, in writing, of changes with the medication.**
- **Medications will be stored in a locked cabinet in the Wellness Office.**

Reviewed Annually 5/10