School Health Program

AUTHORIZATION FOR MEDICATION ADMINISTRATION FORM

NAME OF STUDENT:_____ DATE OF BIRTH:_____

SCHOOL:_____ TEACHER/GRADE:_____

PART I: PARENT/GUARDIAN MEDICATION AUTHORIZATION AND CONSENT FORM

Parent/Guardian: Please complete and sign this action.

I hereby request and authorize the School Nurse/Licensed Practical Nurse/Trained DCPS Personnel to administer prescribed medication as directed by the physician to _____ (student's name). I have read the procedures on the reverse side of this form and agree to assume the responsibilities as required. This medication is a ____ new (or) ____ renewal prescription. If new prescription, enter the date and time the first dose was given at home.

Date:_____ Time:_____ a.m./p.m.

SIGNATURE OF PARENT/GUARDIAN	PHONE	RELATIONSHIP
PLEASE PRINT NAME	WORK/CELL PHONE	DATE

PLEASE TAKE THIS FORM TO STUDENT'S PHYSICIAN FOR

PART II: PHYSICIAN'S AUTHORIZATION MEDICATION ORDER

Physician: Please complete and sign this action. ___Original ___Renewal ___Change

NAME OF STUDENT:_____ DATE OF BIRTH:_____

NAME OF MEDICATION:_____ DOSE/ROUTE:_____

TIME & CIRCUMSTANCES OFADMINISTRATION AT SCHOOL:_____

DIAGNOSIS:_____

EXPECTED DURATION OF SCHOOL ADMINISTRATION:_____

Can a reaction be expected? ____YES ____NO If yes, please describe:_____

***The school nurse must be advised of any changes to this authorization in writing immediately.**

PHYSICIAN SIGNATURE	DATE
PLEASE PRINT NAME	OFFICE PHONE

Please use an office stamp or clearly print the names of any other physicians in your practice concurrently treating this student.

Medication authorization received by:

_____
SIGNATURE OF CSS OR DCPS TRAINED PERSONNEL

_____
DATE