Medication Authorization Form School Year 2024-2025

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

Student: _____ DOB: _____ _Grade:_____

PHYSICIAN/LICENSED PROVIDER – PLEASE COMPLETE

MEDICATIONS REQUIRED DURING SCHOOL HOURS All authorizations expire at the end of the school year or following Extended Year Summer (ESY) session						
Medication/ Treatment	Diagnosis/Reason for Medication	ICD 10 Code	Dose	Time	Route	Possible Side Effects
1.						
2.						
3.						

Inhaler—please include Asthma Action Plan:

☐ Student may carry/self administer his/her inhaler according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.

☐ It is my professional opinion that this student **should not carry** his/her inhaled medication.

Epinephrine auto-injector—please include Anaphylaxis Action Plan:

☐ Student may carry/self administer epinephrine auto-injector (Epi-Pen™) according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.

☐ It is my professional opinion that this student **should not carry** his/her Epi-pen/auto-injector.

Other:

☐ Student may carry/self administer _____ (Please identify).

_____ _____ _____

Signature of Licensed Health Care Provider **Printed name** of Licensed Health Care Provider Date

_____ _____ _____

Clinic Name/Address Clinic Phone # Clinic Fax #

Parent/Guardian Medication Authorization

1. *I request the medication listed be given during school hours as ordered by this student's licensed health care provider. Only daily medications and those for life threatening/emergency conditions will be sent on field trips.*
2. *I will provide the school with physician/licensed prescriber authorization for any change in medication(s) and/or treatment(s). (Example: dosage change, time change, discontinued, etc.)*
3. *I give permission to designated school staff to administer the above medication(s) and/or perform treatment(s). I release the school personnel from any liability in the administration of this medication(s) or treatment.*
4. ***I understand that school health staff cannot administer the medication(s)/treatment(s)/procedure(s) indicated on this form without authorization from both my student's physician/licensed prescriber and guardian/parent.***
5. *I give permission for health office staff to consult with this student's licensed health care provider regarding questions about the above medical condition(s) and medication/procedure being used to treat the condition.*
   Provider name:_____ Clinic name:_____
   Fax:_____
6. *I give permission for the health office staff to communicate **as needed** with school staff about my student's health condition(s) and the action of the medication and/or treatment.*

Parent/Guardian Signature: _____Date:_____

Parent/Guardian name (please print) _____ Tel # _____