



Physician and Parental AUTHORIZATION FOR ADMINISTRATION of Medication in School and During School Activities (2022-23)

Name of Student _____ DOB _____
 Diagnosis _____

A. To be completed by physician:

I request that my patient, as listed above, receive the following medication:

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

DURATION OF TREATMENT ___ 2022/2023 school year (including summer sessions)
 ___ other

**Please note medications will not be administered on early release days, with exception of emergency medication, procedures and treatments.*

Possible Side Effects and Adverse Reactions (if any) _____

PLEASE CHECK ONE:

___ **I deem this child to be NON SELF-DIRECTED** and understand that administration of oral, topical, inhalation and injectable medication must remain the responsibility of the school nurse, physician or parent.

___ **I deem this child to be SELF-DIRECTED** and understand that the school nurse, or other designated person in case of the absence of the school nurse (including field trips) will supervise administration of medication.

___ **I deem this child may SELF-ADMINISTER and SELF CARRY** their own medication with approval of the school nurse.

Physician signature _____ **Date** _____
 Address _____ Phone _____

B: To be completed by the Parent or guardian:

I have consulted with my child’s physician and agree with his/her recommendations. I request my child receive the medication as prescribed above by our physician. The medication is furnished by me in the properly labeled container from the physician.

Parent signature _____ **Date** _____
 Telephone # _____ Cell # _____ Work# _____

Nurse Signature _____ **Date** _____