Authorization for Administration of Medication at School 2017-18

School staff cannot administer the medication(s)/treatment(s)/procedures(s) indicated on this form without authorization from both my student's physician/licensed prescriber **AND guardian/parent.**

Student _____ DOB _____ Grade _____

Diagnosis/Reason for Medication	ICD10 Code	Medication	Dose	Route	Time	Possible Side Effects	**Inhaler ONLY** Self-carry? Y/N

ALL MEDICATIONS (OVER THE COUNTER DRUGS INCLUDED) REQUIRE A PARENT & PHYSICIAN'S SIGNATURE.

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by the student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed by school personnel. The student has been instructed on proper use, side effects, and safeguards regarding this medication.
2. I release school personnel from liability in the administration of any medication(s) or treatment.
3. I will notify the school of any change in medication(s), example – dosage change, medication will be discontinued, etc.
4. I give permission for the health office to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
5. I give permission for MSA staff to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
6. I give permission for the medication(s) to be given by designated personnel as delegated by MSA's nurse.
7. Only FDA approved medications will be administered to a student.
8. All authorizations **expire** at the end of the school year. Please notify staff if you will be picking up any remaining meds.
9. **By signing this form, I understand that school staff cannot administer the medication(s)/treatment(s)/procedures(s) indicated on this form without authorization from both my student's physician/licensed prescriber AND guardian/parent.**

Please sign below for school personnel to administer medication to the student listed on this form:

Parent/Guardian Signature _____ Date: _____ Start Date: _____ Stop Date: _____

Physician's Signature _____ Date: _____

_____	_____	_____	_____
Print or Type Name of Physician/Licensed Prescriber	Clinic Name	Clinic Phone	Clinic FAX

Revised: 06.06.17