AUTHORIZATION FOR MEDICATION/PROCEDURE TO BE ADMINISTERED AT SCHOOL AND AT OFF-CAMPUS SCHOOL SPONSORED EVENTS

PART A

Parent/Legal Guardian to Complete

Name of Student: _____Date of Birth: _____ Grade/Teacher: _____

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school as indicated by my child's physician accordingly below. I understand that I must provide any prescribed medication in its original container/package dispensed by the pharmacist.

I also acknowledge, in accordance with the Nurse Practice Act, the need and give permission for appropriate communication between the school nurse and the medical prescriber related to the medication(s)/treatment(s) in question to enable the nurse to administer safe and effective care. This includes communication concerning the prescription/treatment itself, implementation of the prescription/treatment in school, student response to the medication/treatment, and other pertinent issues related to the student's diagnosis, condition, or medication/ treatment.

_____ _____ _____

Parent/Legal Guardian Signature | Parent/Legal Guardian (Printed Name) | Today's Date

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PART B

Physician to Complete

Current Diagnosis(es): _____ _____ _____ _____

PHYSICIAN MEDICATION AND/OR TREATMENT ORDERS: (Please specify)

Medication/Treatment	Dosage	Time/Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special Instructions: _____

_____

_____ _____ _____

Physician Signature | Physician (Printed Name) | Today's Date

_____

Physician Phone Number