Authorization to Administer Medication at School

Please note: This form must be completed and signed by the parent/guardian **and** the student's Licensed Healthcare Provider, with prescriptive authority. This form is for both **prescription** and **nonprescription** medication. Complete a separate form for **each** medication. All medication must be transported to and from the school by a responsible adult.

PARENT/GUARDIAN REQUEST

STUDENT NAME _____ SCHOOL __ _____

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to dispense medication to the above identified student in accordance with the prescription or LHP's instructions for the period commencing: START DATE _____ TERMINATION DATE_____ or END of SCHOOL YEAR-including summer school activities: Yes_____ No_____

In the event of half-day school schedule, I want my child to take his/her medication at school: Yes_____ No _____

_____ _____ _____

Date Parent/guardian Signature

_____ _____

Home Phone Work Phone

LICENSED HEALTHCARE PROVIDER REQUEST

MEDICATION (Name, Dosage) _____

ADMINISTRATION SCHEDULE _____ _____

REASON FOR MEDICATION _ _____ _____

FURTHER INSTRUCTIONS (possible reactions, etc.): This section must be completed if medication is to be dispensed *for more than 15 days*. _____

_____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period commencing: START DATE_____ TERMINATION DATE _____ or END of SCHOOL YEAR-including summer school activities Yes_____ No_____ , as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

_____ _____

Date Licensed Healthcare Provider Signature

_____ _____

Office Phone Name (please print)