

Authorization for Medication Administration by School Personnel

To: _____ Of: _____
Principal *School Name*

Student Name: _____ DOB: _____ Grade: _____ Teacher: _____

I am giving school personnel permission to administer medications to my child per the following:

Parent or Physician please complete:

<p>Medication: _____</p> <p>Dose (how much): _____</p> <p><small>Tablets requiring cutting should be cut by the parent before being sent to school. Liquid medication requires dosage spoons, available from your pharmacist, to be supplied by parent.</small></p> <p>Route: (Circle one)</p> <p>By: Mouth Ear Eye Nose Skin Inhalation</p> <p>Time to be given @ school: _____</p> <p>Duration: Start date: _____ End Date: _____</p> <p>Reason for Medication:</p> <p>Special Instructions:</p>	<p><input type="checkbox"/> Non Prescription</p> <p><input type="checkbox"/> Prescription Rx number: _____</p> <p><input type="checkbox"/> Please allow my child to self-administer this medication. (refer to district policy on self-medication). Requires self-medication agreement form to be signed by parent, school administrator, and if prescription, consent of physician. (See below)</p>
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I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

Parent/Guarding Signature: _____ Date: _____

This authorization applies only to the medication listed above and for the duration of treatment or school year. This also authorizes an exchange of information, as necessary, between appropriate school personnel, and/or my child's health provider.

Physician Direction

(Required in writing or on pharmacy label for all prescription medication).

- I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate.
- Special instructions including adverse reactions and action required: _____

Physician's Name: (please print/stamp) *Address*

Physician's Signature *Phone#* *Effective Date*

ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.

Self-Medication Agreement for Prescription Inhalers

Students who are developmentally and/or behaviorally able, will be allowed to self-administer prescription inhalers, subject to the following:

1. Self-administration of prescription inhaler requires permission from parent, school administrator and physician. Physician consent is to be included on the prescription label or on the medication consent form.
2. The inhaler must be kept in its appropriately labeled, original container, as follows:
 - Prescription inhaler label must specify the name of the student, name of the medication, dosage, route, and frequency or time of administration and any other special instructions. Physicians consent for self-administration is to be on the label or medication consent form.
3. **Sharing and/or borrowing of the inhaler with another student is strictly prohibited.**
4. **Permission to self-medicate may be revoked if the student violates Archdiocesan school policy governing administration of non-injectable medication and/or these regulations.**

I have read and agree to the above criteria and give permission for my child to carry

(Name of Medication)

(Parent/Guardian Signature)

(Date)

I agree to comply with the above criteria.

(Student Signature)

(Date)

The student may carry and self-administer this medication as prescribed:

(School Administrator or designee)

(Date)