Authorization for Administration of Medication at School 2019-2020

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

Student _____ DOB _____ Grade _____

Diagnosis/Reason for Medication	ICD10 Code	Medication	Dose	Route	Time	Possible Side Effects	Self-Carry? Y/N

ALL PRESCRIPTION MEDICATIONS REQUIRE A PARENT & PHYSICIAN'S SIGNATURE.

OVER THE COUNTER MEDICATION (IBUPROFEN & ACETAMINOPHEN) FOR HIGH SCHOOL STUDENTS ONLY, REQUIRES ONLY A PARENT/GUARDIAN 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 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) to be given 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)/treatments(s)/procedure(s) indication on this form without authorization from both the 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 9.17.19