Authorization Form and Directions for Medication Administration

This form is to be completed by a parent/guardian to request that school personnel administer medication to a student during school hours or during an approved school activity in the event that medication is required for the student to be able to attend.

This form is valid for the current school year and must be completed annually or when there is a medication change. It will be stored in the student's record and a copy must be available to the staff administering the medication and kept with the Administration of Medication Record.

STUDENT INFORMATION		
Student's name:		School name:
Date of birth (mm/dd/yyyy):	Grade:	Homeroom teacher:

Does the student have a Plan of Care for the current school year?

☐ Yes ☐ N/A

If yes, what is the specific health care need and/or medical diagnosis(es):

Please Note:
If there is a Plan of Care that includes the authorization for the administration of emergency medication (e.g. epinephrine auto-injector, glucagon, seizure rescue medication, asthma reliever medication, etc.) this form is NOT required.

PARENT/GUARDIAN		
Name(s) of parent(s)/guardian(s):	Emergency number:	Email:
Name(s) of parent(s)/guardian(s):	Emergency number:	Email:

DIRECTIONS FOR ADMINISTRATION OF MEDICATION: (as per prescription label or non-prescription package directions)

	Medication 1	Medication 2	Medication 3
Name of Medication			
Reason for Medication (e.g., diabetes)			
Medication Administered By	☐ Self-administered, with staff monitoring ☐ Administered by school staff	☐ Self-administered, with staff monitoring ☐ Administered by school staff	☐ Self-administered, with staff monitoring ☐ Administered by school staff
Dose (amount) and Time(s) Medication is Given During School Hours			
How (Route) Medication is Administered (e.g. by mouth, feeding tube*, etc.) ***See below for feeding tubes**			
Additional Instructions (e.g., how to store medication)			

In the rare instance that more than three medications are required, please discuss with your school administrator; additional documents may be required.

FEEDING TUBE MEDICATIONS ONLY *(Also refer to Plan of Care—Tube Feeding.)*

Amount of Water to Flush Through Feeding Tube	Before med: ml After med: ml	Before med: ml After med: ml	Before med: ml After med: ml

Additional Comments:

I hereby request, authorize, and empower my child's school and region to administer the prescribed medication(s) as described herein to the student named above. I release any staff member and the named school and its governing region from any legal liability that may result from the administration of the medication(s) or in the event insufficient medication is available.

I acknowledge and understand that as the student's parent/ guardian I am responsible for ensuring the school has a sufficient amount of the medication(s) to meet the student's needs while at school.

If there is insufficient medication I will be contacted and arrange for the transport of medication to school, or make alternative arrangements for my child for the remainder of the school day.

Parent/Guardian Signature _____ mm/dd/yyyy _____

Authorized Prescriber Signature Required for long-term use (2 weeks or beyond) of non-prescription medications. _____ mm/dd/yyyy _____