NON-EMERGENCY MEDICATION

AUTHORIZATIONS FOR SCHOOL ADMINISTRATION

All prescriptions, INCLUDING over-the-counter medications, must have orders written by a medical provider for administration at school. Medications must be in the original pharmacy labeled; or, product labeled container, (for over-the-counter medications).

(This form is NOT for EMERGENCY medications Epinephrine, Inhalers, Insulin, or Glucagon)

STUDENT NAME:_____DOB:_____/_____/_____GRADE:_____

TO BE COMPLETED BY PARENT OR GUARDIAN

I request that my child receive the medication(s) as prescribed below by my child's medical provider. Medications will be furnished by me in the properly labeled, original container, from the pharmacy/store.

Parent/Guardian Printed Name:_____

Daytime Contact Phone Numbers:_____(W)_____(C)_____(H)

Parent/GuardianSignature:_____Date:_____

TO BE COMPLETED BY HEALTH CARE PROVIDER

I request that my patient, as listed above, receive the following medication(s):

MEDICATION(S)	DOSAGE/ROUTE	FREQUENCY/TIME

Reason for medication(s):_____

Duration of Treatment:_____

Possible Side Effects/Adverse Reactions:_____

If your patient is able to SELF-ADMINISTER his/her medication during extracurricular activities, such as sports, clubs, etc.; and/or, during field trips, please check the box below:

[ ] My patient meets the *criteria to be able to self-administer his/her medication during extracurricular activities and during field trips. _____Provider Initials

* **Criteria for "self-administration":** *He/she can recognize the medication; understands the purpose, name, amount, dose, timing, and effect of taking, or not taking, medication(s); and, he/she is considered responsible and independent in the medication delivery; and, will only need assistance during emergencies.*

Health Care Provider's Signature:_____Date:_____

Health Care Provider's Printed Name or Stamp:_____

Address:_____Phone:_____