

 **MEDICATION AUTHORIZATION FORM**

 For ALL prescription or over the counter medications administered at school

**Student**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **DOB**: \_\_\_\_\_\_\_\_  **Grade:**\_\_\_\_\_\_\_

**School:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **School Year**:\_\_2019-2020\_ **Teacher:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH CARE PROVIDER** **complete this section** (MD, DO, ND, DMD, PA, or ARNP) **Please Print**

|  |  |
| --- | --- |
|  **Medication:** Name/Dose/Time/Route | Medication Dose Route Time |
| **Reason/Diagnosis:** |  |
| **Side Effects:** |  |
|  **Repeat Dose?** | May repeat every:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **Is student Capable of** **Self-carry & Safe** **Administration?** | No- **Student may not self-carry or administer**    Yes - **Student may self-carry/administer**  **Student has been trained in:** Purpose, method, frequency, and safe carry of this medication   |
| **Authorization for:** |  **THIS School Year** (includes Summer) Other dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**Signature: Licensed Health Care Provider Print Name Date:   | Phone: |
| Fax: |

**PARENT/GUARDIAN** **complete this section**

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| --- |
| I request authorized school staff to assist my student in taking the medication in accordance with instructions indicated above as there exists *a valid health reason which makes administration of medication advisable during school hours.* Medication may be administered by an unlicensed assistive staff member.**Self-Carried and Administered by Student** **ALL Grades:** I request my student Self-Carry and Self-Administer Asthma/Anaphylaxis medication.   (Requires School Nurse approval: Approval Granted by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) **Only Grades 6-12:** I request my student Self-Carry and Self-Administer this medication.  Student carries only 1-day supply. **EXCLUDES: Controlled Substances** (Requires school nurse approval: Approval Granted by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) * I will provide medication in the original labeled container.
* I understand that the School Nurse may contact the prescriber regarding questions related to this medication.
* I understand the responsibility of self-carrying medication at school; school staff will not be able to track compliance.
* As the parent/guardian/or other person in legal control of the above student I agree to hold harmless and indemnify the school and Auburn School District’s officers, employees, and agents against all claims, judgements, or liabilities arising out of self-administration and self-carrying of medication by student.
* I understand the student, if approved to carry medication, will carry the one day supply in the original labeled container.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:Parent / Guardian / StudentDate: Phone:  |

ASD Medication Policy: 3416, 3419

HS860 (5/19)