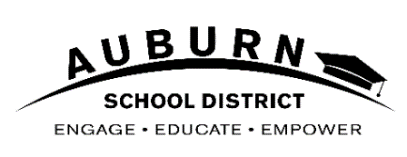
[](https://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&ved=2ahUKEwizl_TlhsXbAhUFM30KHc8_CrAQjRx6BAgBEAU&url=https://www.auburn.wednet.edu/domain/36&psig=AOvVaw0Rh-U7RI-ngpJsQY74EfOp&ust=1528581184834848)

**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**

|  |
| --- |
| 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)