AUBURN SCHOOL DISTRICT
ENGAGE • EDUCATE • EMPOWER

MEDICATION AUTHORIZATION FORM

For ALL prescription or over the counter medications administered at school

Student: _____ **DOB:** _____ **Grade:** _____

School: _____ **School Year:** _____ **Teacher:** _____

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

Medication: Name/Dose/Time/Route				
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:

			Phone:
Signature: Licensed Health Care Provider	Print Name	Date	Fax:

PARENT/GUARDIAN complete this section

Administered by Staff

☐ **ALL Grades:** I request authorized school staff to assist my student in taking the medication described above.

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/Student	**Date**	**Phone**

ASD Medication Policy: 3416, 3419
HS860 (1/19)