



School Health Program
AUTHORIZATION FOR MEDICATION ADMINISTRATION FORM

NAME OF STUDENT: DATE OF BIRTH:

SCHOOL: TEACHER/GRADE:

PART I: PARENT/GUARDIAN MEDICATION AUTHORIZATION AND CONSENT FORM

Parent/Guardian: Please complete and sign this action.

I hereby request and authorize the School Nurse/Licensed Practical Nurse/Trained DCPS Personnel to administer prescribed medication as directed by the physician to (student's name). I have read the procedures on the reverse side of this form and agree to assume the responsibilities as required. This medication is a new (or) renewal prescription. If new prescription, enter the date and time the first dose was given at home.

Date: Time: a.m./p.m.

SIGNATURE OF PARENT/GUARDIAN PHONE RELATIONSHIP
PLEASE PRINT NAME WORK/CELL PHONE DATE

PLEASE TAKE THIS FORM TO STUDENT'S PHYSICIAN FOR

PART II: PHYSICIAN'S AUTHORIZATION MEDICATION ORDER

Physician: Please complete and sign this action. Original Renewal Change

NAME OF STUDENT: DATE OF BIRTH:

NAME OF MEDICATION: DOSE/ROUTE:

TIME & CIRCUMSTANCES OF ADMINISTRATION AT SCHOOL:

DIAGNOSIS:

EXPECTED DURATION OF SCHOOL ADMINISTRATION:

Can a reaction be expected? YES NO If yes, please describe:

\*The school nurse must be advised of any changes to this authorization in writing immediately.

PHYSICIAN SIGNATURE DATE

PLEASE PRINT NAME OFFICE PHONE

Please use an office stamp or clearly print the names of any other physicians in your practice concurrently treating this student.

Empty box for office stamp or concurrent physician names.

Medication authorization received by: SIGNATURE OF CSS OR DCPS TRAINED PERSONNEL DATE