

**Parent Consent and Authorized Health Care Provider Authorization for Management of Medication
 Administration at School and School-Sponsored Events**

Student:	Date of Birth:	Grade:
School:	Teacher:	School Year:

1. **Name of medication** (one medication per form): _____
 Prescription Over-the-counter (non-prescription) Controlled medication
2. **Reason for medication:** _____
3. **Method of administration:**
 oral g-tube nebulizer inhaled injection topical Other: _____
4. **Amount/Dosage of medication** (be specific, i.e., ml, mg, etc.): _____
5. **Time(s) of day to be given at school:** _____
 As needed **PRN** Frequency: _____
 List specific symptoms that would necessitate administration of the **PRN** medication and indications for referral for a medical evaluation: _____

6. **Possible side effects:** _____
7. **Additional recommendations:** _____

Authorized Health Care Provider Authorization for Management of Medication Administration in School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

In my professional opinion, the above named student is competent to safely carry and self-administer the above named medication according to the condition(s) in the above written statement.

Authorized Health Care Provider Name _____ **Signature** _____
Phone _____ **Address** _____ **City** _____ **Zip** _____ **Date** _____

Parent Consent for Authorization and Management of Medication Administration in School Setting

I the undersigned, the parent/guardian, of the above named student, request that the specialized physical health care service, medication administration be administered to my child in accordance with state laws and regulations.

1. I give consent for the school nurse, other duly qualified supervisor of health, or site administrator to communicate with the authorized health care provider and the pharmacist with regard to the provider's written statement.
2. I will provide the necessary medication, supplies and equipment.
3. I will notify the school nurse, other duly qualified supervisor of health, or the site administrator if there is a change in child's medication, health status or authorized health care provider.
4. I will notify the school nurse, other duly qualified supervisor of health, or site administrator immediately and provide new consent for any changes in authorized health care provider's authorization.

I, the parent/guardian of the above named student, request that my child carry and self-administer his/her medication as authorized above.
Signature of Parent/Guardian _____ **Date** _____

NOTE During early dismissal days and Extended School Year Program, Specialized Physical Health Care Procedures ordered on or after dismissal time will not be administered at school. Parent/guardian to provide at home. (Excluding "Emergency" SPHCS).

Reviewed by school nurse (Signature): _____ Date: _____