Authorization to Administer Medication in Program

Student Name:_____DOB:_____Grade: _____
Last Name, First Name

Part I

Dear Parent or Healthcare Provider,

When considered medically necessary, students may receive medications and treatments as ordered by a licensed healthcare provider, during the program day. Please complete the following information. Be advised that:

Orders are valid for one program year.

- NO MEDICATION OR TREATMENT may be given by the program nurse or designee until this form is completed and properly labeled medication is received. THIS INCLUDES OVER THE COUNTER MEDICATIONS SUCH AS TYLENOL, MOTRIN, AND COUGH DROPS.
- A physician signature and a parent signature must be on this form.
- All mediations must be stored in their original containers with an appropriate pharmacy label on each bottle. All labels will include the student's name, does, frequency, route, time of administration of the medication.

Part II

Dear Healthcare Provider,

The parent initiates this request and has the responsibility for supplying medication and/or treatment supplies. Should the student display any adverse reactions, the parent will be contacted immediately, emergency care will be provided as needed and the medication/treatment discontinued. The parent will be responsible for contacting you for follow-up care as you deem necessary. Please sign below, acknowledging that you understand the procedure for management of side effects to prescribed medications or treatments. Thank you for your assistance.

Part III

Medication Treatment #1:

Name of Drug/Treatment _____

Dosage_____Route_____Frequency_____(include times and duration)

Medication form __ pill/capsule __ inhaler __ear drops __ eye drops __ liquid __ injectable

Known adverse reactions/side effects _____

Prescribed treatment for side effects, if other than as outlined above _____

Medication Treatment #2:

Name of Drug/Treatment _____

Dosage_____Route_____Frequency_____(include times and duration)

Medication form __ pill/capsule __ inhaler __ear drops __ eye drops __ liquid __ injectable

Known adverse reactions/side effects _____

Prescribed treatment for side effects, if other than as outlined above _____

Medication Treatment #3:

Name of Drug/Treatment _____

Dosage_____Route_____Frequency_____(include times and duration)

Medication form __ pill/capsule __ inhaler __ ear drops __ eye drops __ liquid __ injectable

Known adverse reactions/side effects _____

Prescribed treatment for side effects, if other than as outlined above _____

Part IV

Parent Permission:

I hereby give permission for my child to receive the above medications/treatments during program hours. I understand that medications may be administered by the program registered nurse or designee. This designee may be a non-medical person. If a treatment requires a medical or nursing assessment prior to administration, and a licensed medical person is not available, the medication and/or treatment will not be given. This medication and/or treatment is considered a medical necessity and ordered by a licensed healthcare provider. I hereby release the FAUS District, its agents and employees from any and all liability that may result from my child receiving this medication and/or treatment.

_____	_____	_____	_____
Parent/Guardian Signature	Date	Healthcare Provider Signature	Date
_____	_____	_____	_____
Parent/Guardian Name (Print)	Phone #	Healthcare Provider Name (Print)	Phone #

Do Not Write Below This Line-Program Use Only

Comments: _____

_____

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Medication/Treatment Received

Date:_____Amount:_____Approved by:_____(Program Nurse Signature)
Logged in Medical Administration Book: D Yes ___ No Secured in locked cabinet: ___ Yes ___ No

Date:_____Amount:_____Approved by:_____(Program Nurse Signature)
Logged in Medical Administration Book: ___Yes ___No Secured in locked cabinet: ___ Yes ___ No

Date:_____Amount:_____Approved by:_____(Program Nurse Signature)
Logged in Medical Administration Book: ___Yes ___ No Secured in locked cabinet: ___ Yes ___ No

Date:_____Amount:_____Approved by:_____(Program Nurse Signature)
Logged in Medical Administration Book: ___Yes ___ No Secured in locked cabinet: ___ Yes ___ No

Date:_____Amount:_____Approved by:_____(Program Nurse Signature)
Logged in Medical Administration Book: ___Yes ___ No Secured in locked cabinet: ___ Yes ___ No

Date:_____Amount:_____Approved by:_____(Program Nurse Signature)
Logged in Medical Administration Book: ___Yes ___ No Secured in locked cabinet: ___ Yes ___ No