SCHOOL MEDICATION AUTHORIZATION FORM

Name of Student _____ Birth date _____

Address_____ Phone _____

Liberty Unit School District #2___ Grade_____ Teacher_____

Part I: Licensed Prescriber's Statement **Doctor's Name**_____

1. Name/type of medication_____
2. Dosage/Amount to be given_____
3. Route of Administration_____
4. Frequency/times to be administered at school_____
5. Duration (week, month, indefinite, etc.)_____
6. Discontinuation Date_____
7. Intended effects of medication_____
8. Expected side effects_____
9. Diagnosis requiring medication_____
10. Other medication child is receiving_____
11. Time interval for re-evaluation_____
12. Known allergies to Medication_____

_____

Licensed Prescriber's Signature Address Phone Emergency Phone Date

Note: Students may independently administer their own inhaled medication if ordered to do so by the physician and they have the written permission of his/her parent/guardian. Physician and Parental Authorization for Self-Administration of Asthma Medication forms must be completed by the physician and the parent/guardian prior to self-administration.

Part II: Parent/Guardian Request/Approval

I hereby request and give my permission for the above named school to administer the medication prescribed on this form to my child

_____

Parent/Guardian Signature Home Phone Work Phone Emergency Phone Date

PLEASE READ THE MEDICATION ADMINISTRATION POLICY LISTED ON WEBSITE