Colton School District #306

Authorization for Administration of Medication at School

Student Name: _____ Birth date: _____ Grade: _____

This Portion to be Completed by Physician

Name of Medication	Dosage	Method of Administration	Time To Be Given

Possible Side Effects of Medication:_____

In given PRN, specify the length of time between doses: _____

If request pertains to inhaled medication or Epi Pens:

The above named student has demonstrated their ability to self-administer this medication.

☐ Yes ☐No

Is this student able to carry his/her inhaler/Epi Pen on their person?

☐ Yes ☐No

I request and authorize the above-named student to be administered the above identified medication in accordance with the instructions indicated above from _____ to _____ (not to exceed the current school year) as there exists a valid health reason which makes administration of medication necessary during school hours.

_____ _____

Physician Signature Date

_____ _____

Telephone Number Printed Name

This Portion to be Completed by Parent/Guardian

I have read and accepted the conditions of the school medication policy. I request and authorize the school to administer the above medication to the above listed student in accordance with the doctor's instructions for the period of time between _____ to _____ (not to exceed the current school year).

Permission to carry Inhaler/Epi Pen? ☐ Yes ☐No

Permission to self-administer medication? ☐ Yes ☐No

_____ _____

Parent/Guardian Signature Date

In order for a student to carry of self-administer an Inhaler or Epi Pen, it must be approved by the physician, parent, and school nurse.