Medication Authorization Form

Student Information

Student Name:	DOB:
Parent/Guardian:	Phone:
Allergies:	School Year:

Permission for Over-the Counter Medications

□ Tylenol □ Ibuprofen □ TUMS □ Cough Drops

Prescription Medication(s) □ N/A

Name of Medication:		Diagnosis:	
Dosage:	Route:	Time/Frequency:	Start Date:
Special Instructions:			
Name of Medication:		Diagnosis:	
Dosage:	Route:	Time/Frequency:	Start Date:
Special Instructions:			

Epinephrine Auto Injector □ N/A Dose: □ 0.15mg □ 0.30mg

Epinephrine Auto Injector Self-Carry: □ N/A

□ As the prescriber, I have provided the student with training in the proper use of the auto-injector and determined that this student is capable of keeping and using the auto-injector appropriately.

Asthma Inhaler Medication □ N/A □ Albuterol □ Proventil □ Advair □ Symbicort □ Other:_____

Asthma Inhaler Self-Carry: □ N/A

□ As the prescriber, I have provided the student with training in the proper use of the inhaler and determined that this student is capable of keeping and using the inhaler appropriately.

Provider Authorization

Prescriber Name:	Phone:	Fax:
Prescriber Signature:	Date:	

Parent/Guardian Authorization

I authorize trained school staff to administer the above named medication(s) in appropriate doses,, and if applicable allow my student to self carry their medication and administer it themself.

Parent Signature: Date:

School Nurse Signature: Date: