Meridian School District

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Nurse Phone (360) 318-2176 Nurse Fax (360) 318-2392

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

SCHOOL YEAR: _______________

STUDENT NAME: ______________________________ DOB: ____________ GRADE: ____ SCHOOL: ___________________

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

PRESCRIBER INFORMATION

LICENSED PRESCRIBER'S NAME: ____

BUSINESS PHONE: _________________________________ FAX: ____________________________________

MEDICATION INFORMATION

NAME OF MEDICATION: ____ DOSAGE: _____________________

TIME(S) TO BE GIVEN: ______________________________ ☐ORAL ☐INJECTED ☐INHALED ☐ OTHER: ________________

START DATE: _______________ END DATE: _______________ *NOT TO EXCEED THE SCHOOL YEAR

NAME OF MEDICATION: ____ DOSAGE: _____________________

TIME(S) TO BE GIVEN: ______________________________ ☐ORAL ☐INJECTED ☐INHALED ☐ OTHER: ________________

START DATE: _______________ END DATE: _______________ *NOT TO EXCEED THE SCHOOL YEAR

DIAGNOSIS OR REASON FOR MEDICATION(S): ____

IF GIVEN, PRN, SPECIFY LENGTH OF TIME BETWEEN DOSES: ____

INHALERS: ____ STUDENT CARRIES: ☐ YES ☐NO

STUDENT IS CAPABLE OF SELF ADMINISTRATION OF MEDICATION: ☐YES ☐NO *STUDENTS ARE NOT ALLOWED TO SELF-ADMINISTER CONTROLLED SUBSTANCES

POSSIBLE SIDE EFFECTS OF MEDICATION: ____

EMERGENCY PROCEDURE IN CASE OF SERIOUS SIDE EFFECTS: ____

I request & authorize that the above-named student be administered the above identified medication in accordance with the instructions indicated above, as there exists a valid health reason which make administration of the medication advisable during school hours.

____ ______________
SIGNATURE OF LICENSED HEALTH PROFESSIONAL DATE

PARENTAL CONSENT

THIS PORTION TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

- I REQUEST/AUTHORIZE THE MERIDIAN SCHOOL DISTRICT TO ADMINISTER MEDICATION TO THE ABOVE IDENTIFIED STUDENT IN ACCORDANCE WITH THE LHP'S INSTRUCTIONS: ☐YES ☐NO
- I GIVE PERMISSION FOR MY CHILD TO SELF-ADMINISTER MEDICATION IF THE SCHOOL NURSE DETERMINES IT IS SAFE AND APPROPRIATE: ☐YES ☐NO *STUDENTS ARE NOT ALLOWED TO SELF-ADMINISTER CONTROLLED SUBSTANCES
- I GIVE PERMISSION FOR MY CHILD TO CARRY AN INHALER: ☐YES ☐NO
- I GIVE PERMISSION FOR MY CHILD TO CARRY THEIR MEDICINE: ☐YES ☐NO

_______________________________ _______________________________ ______________
PARENT/GUARDIAN NAME PARENT/GUARDIAN SIGNATURE DATE

__________________________________ __________________________________
HOME PHONE WORK/CELL PHONE