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