AUTHORIZATION OF MEDICATION AT SCHOOL

Student _____ **Date of birth** _____

School _____ **Grade** _____

PARENT/GUARDIAN PLEASE READ and COMPLETE THIS PORTION

- I request the listed medication be given as ordered by the licensed healthcare professional.
- I give health services staff permission to communicate with the medical office about this medication. I understand certain medication may be administered by non-licensed staff members who have been trained and are supervised by a registered nurse.
- I understand medication information may be shared with all school staff working with my child and emergency staff, if necessary.
- All medication must be brought to the school in its original container with instructions as noted below by the licensed healthcare professional.
- I request and authorize my child to carry and/or self-administer their medication. ☐ Yes ☐ No

_____

PARENT/GUARDIAN SIGNATURE DATE

Home phone _____ **Work or cell phone** _____

THIS SECTION TO BE COMPLETED ONLY BY A LICENSED HEALTHCARE PROFESSIONAL

(please print clearly)

Medication Name	Diagnosis/Reason for Medication	Dosage	Administration Method	Time(s) to be Taken

- I request and authorize this student to carry their medication: ☐ Yes ☐ No
- I request and authorize this student to self-administer their medication: ☐ Yes ☐ No
- List possible medication side effects: _____

I request and authorize the above-named student be administered the above identified medication in accordance with the indicated instructions from _____ to _____ (not to exceed the current school year).

Name of licensed healthcare professional (please print) _____

Contact number _____

_____

SIGNATURE OF LICENSED HEALTHCARE PROFESSIONAL DATE

Adapted from Missouri DHSS – Guidelines for Allergy Prevention and Response