Granite Falls School District

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: ____ Birth Date: ___________________________________

School: ____ Grade: ______________________________________

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

(Please clearly print legible instructions)

Name of Medication	Dosage	Method of Administration	Time(s) to Be Take
_________________________________	___________	__________________________	_______________________

Diagnosis or reason for medication: ____

If give PRN, specify the minimum length of time between doses: ____

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

I request and authorize this student to self-administer their medication under the supervision of Health Service Staff. _____ Yes _____No

This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

Possible medication side effects: ____

Emergency procedure in case of serious side effects: ____

I request and authorize the above-named student to be administered the above identified medication in accordance with the instructions indicated above valid for the current school year including summer school unless otherwise indicated. **(not to exceed current school year).** There exists a valid health reason which may make administration of the medication advisable during school hours.

____ ____

Date of Signature | Licensed Health Professional (LHP)

____ ____

Telephone Number | Name (please print)

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request this medication to be given as ordered by the licensed health professional.
- I give Health Services Staff permission to communicate with the medical office about this medication. I understand oral medications may be administered by non-licensed staff members who have been trained and are supervised by a Registered Nurse.
- Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must be brought to school in its original container with instructions as noted above by the licensed health professional.
- I request and authorize my child to carry and/or self-administer their medication. ____ Yes ____ No

____ ____

Date of Signature | Parent/Guardian Signature

Telephone numbers: ______________________ (home) ____________________ (work) ________________________ (cell)

Reviewed by Registered Nurse: ____ Date: _________________

Revised 05/2015