Intermediate School District 917

Authorization and Request for Administration of Medications

Student ______________________________ **Birth Date** ______________**School Year** _________

Primary Dx____ **ICD-10 Diagnosis:** ____________

Drug Allergies: **Yes** **No**

If yes, list ____

- ❑ For asthma inhaler medication, please complete an *Asthma Action Plan* form.
- ❑ For seizure rescue medications, please complete *Annual Health Information* and *Annual Action Plan for Student with Seizure History* forms.
- ❑ For an epi-pen rescue medication, please complete an *Anaphylaxis Medication Authorization and Plan.*

Medication ___________________________ Time(s) ___________ Duration ___________

Dose ______________ Route* _______________ Reason ______________________________

Medication ___________________________ Time(s) ____________ Duration ___________

Dose ______________ Route* ____________ Reason ________________________________

*Route is the manner in which the medication is administered (by mouth, per gastrostomy tube, nebulization, etc.).

....

<u>Parent/Guardian Authorization</u>

❑ I authorize the school nurse to contact the licensed provider as needed concerning this medication/s.

Provider/Clinic ______________________________________ Phone # ______________ Fax # _______________

- I understand that I am to furnish all necessary medications.
- I understand that parent/guardian authorization is required for any prescriptive or non-prescription medication to be given at school. Prescription medications must have a physician or licensed provider authorization. Physician authorization may be required for a prescriptive medication PRIOR to administration on the discretion of the Licensed School Nurse (LSN).
- Non-prescriptive medications may also require physician approval at the discretion of the LSN or policy of health services where child attends.
- Students are prohibited from using a medication that is not authorized for their personal use.
- I will notify the school immediately if my child's health status changes, or there is a change or cancellation of the medications.
- I understand all medications must be provided with an accurately labeled prescription container. (**Please ask your healthcare provider for the medication to be divided into two containers, one for 'school,' one for 'home.'**) Non-prescriptive medications must be in an original container with label and directions.
- **The medication may not necessarily be administered by a school nurse. The medication may be administered by school personnel trained and supervised by a licensed school nurse.**
- I have read this *Parent/Guardian Authorization* section and agree to the instructions it provides.

Parent/Guardian Signature ____________________________ **Date** ____________________

....

PHYSICIAN AUTHORIZATION REQUIRED FOR ALL PRESCRIPTION MEDICATIONS

<u>Physician Authorization</u>

List special instructions and/or possible side effects: ____

Physician Signature _________________________________ **Date** ____________________

For office use only:
LSN Signature ________________________________ Date ________________
Name of Staff Routing _____________________________ Date ________________
Please check off who was routed this form ___Student File ___IEP Manager ___ 917 LSN ___Building Nurse