VISTING NURSE HEALTH SERVICES
SCHOOL HEALTH PROGRAM
MEDICATION AUTHORIZATION

Student _____ Grade _____ Age _____ School _____

PHYSICIAN DIRECTIONS

Medication to be given _____

Dosage _____ Route _____ Time _____

Starting Date _____ Termination Date _____

Purpose of medication _____

Possible side effects/observations to note _____

Physician requests comments from school? Yes_____ No _____

This medication may be safely given by an unlicensed individual who has demonstrated competency in medication provision.

Physician Signature _____ Phone _____ Date _____

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I request the student above receive the medication as ordered by the physician while in school and school related activities. I understand it is my responsibility to furnish the medication in the original container or prescription bottle appropriately labeled by the pharmacy or physician stating name of medication, dosage and instructions. I accept the responsibility of monitoring the action and side effects of the medication and ask that I be notified if the following occurs:

Parent/Guardian Signature _____

Address _____

Phone _____ (home) _____ (work) _____(cell)

Complete this section in addition, ONLY if medication is PRN/as needed:

Medication should be provided when _____
Notify if/additional instructions _____
I find the following unlicensed individual/s competent to provide the medication stated above:
_____

Parent Signature _____ Date _____

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Complete this section in addition, ONLY if medication is to be given by route OTHER THAN oral, inhalation, topical or instillation:

Written procedure (may be attached):

I find the following unlicensed individual/s competent to provide the previously stated medication:

_____

Parent Signature _____Date _____

Complete this section in addition, ONLY if participation in monitoring is necessary:

I request that the following observations me made and reported to me in the time lines stated:

_____

If find the following unlicensed individual/s competent to assist in monitoring the previously stated medication: _____

Parent Signature _____ Date _____

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Parents, please take note, **NEW MEDICATION PRACTICE REQUIREMENT**:

Please notice our new medication procedure. ** Medication can be brought in during Registration Days **

All medication is to be brought to the office when the student arrives at school in the morning. Parents are required to conduct an exact count of the medication and present it to the school along with the medication. Upon medication arrival at school, the health office will also conduct a count of the medication. The medication count must match that provided by the parent/guardian. The parent/guardian will be contacted to conduct a medication count if a count is not provided or if a discrepancy in the count occurs.

Date pills received _____
Parent count _____
Health office count _____
Signature _____

Date pills received _____
Parent count _____
Health office count _____
Signature _____

Date pills received _____
Parent count _____
Health office count _____
Signature _____

Date pills received _____
Parent count _____
Health office count _____
Signature _____

Date pills received _____
Parent count _____
Health office count _____
Signature _____

Date pills received _____
Parent count _____
Health office count _____
Signature _____