VISITING 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_____

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) _____(other)

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_____