AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT GRIFFIN SCHOOL

Student's Name ______________________________ Birth date ____________________

Home Room Teacher ________________________ Grade ____________________

THIS PORTION TO BE COMPLETED AND SIGNED BY THE LICENSED HEALTH PROFESSIONALIF IT IS NECESSARY TO DISPENSE MEDICATION DURING SCHOOL HOURS

NAME OF MEDICATION	DOSAGE	METHODS OF ADMINISTRATION	TIME OF DAY TO BE TAKEN
________________	____________	______________	____________

If prn - specify the length of **time between doses:** ______________________________

Reason for medication to be given during school hours: ___________________________

Permission to carry (circle) **Inhaler: YES ____ NO ____; EpiPen: YES ____ NO____;**
Insulin: YES ____ NO ____ (insulin injection may not be delegated to unlicensed staff)

Possible **side effects** of medication: ______________________________________

Emergency procedure in case of serious side effects: ____________________________

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I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above from __________________ to __________________. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by trained school personnel.

____________________ ______________________________
Date of Signature Licensed Health Professional

____________________ ______________ ____________________
Telephone Number Fax Name (Please Print or Type)

____
Address: City Zip code

THIS PORTION TO BE COMPLETED AND SIGNED BY THE PARENT/GUARDIAN.

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or instructions from a licensed health professional.

MEDICATION MUST BE SUPPLIED TO THE SCHOOL IN THE ORIGINAL CONTAINER; AND THE WRITTEN AUTHORIZATION MUST MATCH EXACTLY THE INFORMATION ON THE CONTAINER.

I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed. Permission granted to exchange medication information with the nurse.

______________ ____________________ ______________ ______________
Date of Signature Signature Home Phone Work Phone

REVIEWED BY __________________________ (SCHOOL NURSE) **DATE** ____________