Cannon Kids

MEDICATION AUTHORIZATION FORM

Student _____

D.O.B. _____ School _____

Grade _____ Date _____

☐ Student has 504 Plan ☐ Student has IEP

1. PARENTAL PERMISSION is required for any and all medication administered at school.
2. PHYSICIAN PERMISSION is required for all prescription medication.*

*NOTE: Over-the-counter non-prescription medication AND prescription antibiotics (less than 2 weeks - antibiotics) can be administered with parental permission alone.

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1. PARENT/GUARDIAN PERMISSION

I hereby give my permission for my child, _____, to receive the following medication at school as prescribed in writing by my child's physician. I understand my signature gives permission to School District Health Services staff to contact the signing physician in regard to this medication. Medication administration is a rendered service by the School District and I understand the School District does not assume responsibility for this matter.

Medication _____ Dosage _____ mg/ml Time _____

Physician's Name _____ Clinic _____

Clinic Address _____ Phone _____

Is your child taking any other medication presently? ☐ Yes ☐ No *If yes, please specify:* _____

_____

_____

➢ Parent/Guardian signature Phone number Date

2. PHYSICIAN'S WRITTEN ORDER

STUDENT NAME _____

Medication _____ Dosage _____ mg/ml Time _____

Diagnosis _____

Possible side effects _____

➢ Physician signature _____

Date _____

Student has met criteria for self-administration of the following medication.

Recommended for MS/HS only

☐ Asthma-Inhaler administration
☐ Diabetes-Insulin and BG monitoring
☐ Anaphylaxis-EpiPen administration
☐ Other: _____

PLEASE SIGN THIS FORM AND RETURN TO SCHOOL WITH MEDICATION