St. Augustine School

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

In order to protect the health and safety of all students, schools must have a written provider order and written parent/guardian consent in order for a student to be administered a medication, or to permit a student to self-administer their medication at school. A provider order is required for both prescription and non-prescription medications. A provider order is valid for the school year in which it is written, unless the provider changes the order, writes the order for a shorter period of time, or discontinues the order.
The following must be completed:

1 Written authorization from the parent.
2 Written, signed orders from the physician or other healthcare provider
3. The original prescription bottle of medication, or the original over the counter bottle, properly labeled as to its contents.

A. To be completed by the parent or guardian:

I request that my child _____DOB _____ receive the medication as prescribed below by our physician.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by physician:

Name of Student _____ DOB _____

Medication _____

Diagnosis and ICD Code: _____

Dosage and Route of Medication: _____

Frequency/Time to be given: _____

If prn, for what symptoms: _____

Duration of Treatment: _____

<u>*PLEASE COMPLETE IF APPLICABLE* :</u>

Health Care Provider Permission for Independent Use and Carry:
I attest that this student has demonstrated to me that they can self-administer the medication listed below safely and effectively, and may carry and use this medication (with delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ _____ which requires rapid administration of _____
  (state diagnosis) (medication name)

Physician's Signature: _____ Date: _____

Physician's Name and Title (print): _____ Phone: _____

Providers Address: _____