AUBURN ENLARGED CITY SCHOOL DISTRICT

School Health Services

PARENT AND PRESCRIBER'S AUTHORIZATION
FOR ADMINISTRATION OF MEDICATION IN SCHOOL

To be completed by parent/guardian:
I request that my child _____, grade _____, receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the **PROPERLY LABELED ORIGINAL CONTAINER FROM THE PHARMACY.** I understand that the school nurse, or other designated person in the absence of the school nurse, will administer the medication. I hereby authorize the Auburn Enlarged City School District to release information to and receive information from the health care provider named below.

Signature Parent/Guardian _____

Address: _____

Telephone: Home _____ Work _____ Date _____

To be completed by the licensed health care prescriber:
I request that my patient, as listed below, receive the following medication:

Name of student: _____ Date of birth _____

Diagnosis: _____

Name of medication:

Prescribed dosage, frequency and route of administration: Indicate all prescribed doses during home/school hours: _____

Time to be taken during school hours: _____

Duration of treatment: _____

Possible side effects and adverse reactions (if any): _____

_____

Other recommendations: _____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

AUBURN ENLARGED CITY SCHOOL DISTRICT
School Health Services

SELF-MEDICATION RELEASE FORM

Date: _____

Student's Name: _____ has been instructed in the proper use of the following medication procedures:

_____

We, (*physician's signature*) _____ and

(*parent/guardian's signature*) _____ request that

(*student's name*) _____be permitted to

carry the medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

I, (*school nurse*) _____have observed

(*student's name*) _____ on (*date*) _____ and

DO / DO NOT feel that he/she is properly administering his/her medication as prescribed.

Parent notified [date] _____

Physician notified [date] _____

*Note: This form must be completed **in addition** to the routine district medication form for those students who request permission to carry their own medication on campus or keep this medication in a P.E. locker.*