



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 _____ On file at central office _____

Parent Signature _____ Date _____