



**AUTHORIZATION FOR MEDICATION
or PROCEDURE ADMINISTRATION**
Board Policy 504.12-E(ii)

Student: _____ Birthdate: _____
 School: _____ School Year: _____

Medication/Procedure, which cannot be managed at home, shall be administered at school when the following are on file at the school:

- Physician's signed and dated authorization which includes the: medication/procedure, dosage, route, and time to be given at school, dosage repeat, symptoms, and side effects.
- Parent/Guardian signed and dated authorization.
- Medication/equipment delivered to school in the original packaging.
- A prescription label must be attached to the medication container(s).
- Authorization orders must match the prescription label on the medication container(s).
- Annual renewal of authorization and immediate notification, in writing, of changes.
- Medication/Equipment will be kept in a secured area and shall be administered by qualified staff.

MEDICAL PROVIDER AUTHORIZATION SECTION (To be filled out by medical provider)

The above named student is under my medical supervision. I have prescribed the following:

Name of Medication mg or Procedure	Dosage @ school	Route

Time given @ school _____ **Diagnosis & ICD-10 code (Must have for Medicaid)** _____

Anticipated reactions/possible side effects _____

Physician Signature _____ Date _____
 Phone _____ Fax _____

PARENT AUTHORIZATION SECTION

I request the above pupil be given the following while in school and school related activities. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication/procedure where the person administering the medication/procedure acts as an ordinarily reasonable prudent person would under the same or similar circumstances.

Name of Medication/mg or Procedure	Dosage @ school	Time @ school	Route

Child's Physician _____

Parent Signature _____ **Date** _____

Phone: Home _____ Work _____ Cell _____

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