

AUTHORIZATION FOR MEDICATION / TREATMENT

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____
School: _____ **Phone #:** _____ **Fax#:** _____

Allergies: _____

Diagnosis: _____

MEDICATION	DOSAGE & ROUTE	FREQUENCY	SPECIFIC TIMES	SPECIAL INSTRUCTIONS/SIDE EFFECTS

TREATMENTS DURING SCHOOL HOURS

Treatment Plan: _____

PROCEDURE	TYPE	MEDS / FEEDING AMOUNT	FREQUENCY SPECIFIC TIMES	RATE / FLOW
Catheterization				
Feedings	<input type="checkbox"/> G-Tube <input type="checkbox"/> J-Tube <input type="checkbox"/> NG-Tube <input type="checkbox"/> Special			
Suctioning	<input type="checkbox"/> Oropharynx <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Deep <input type="checkbox"/> Surface			
Tracheostomy	<input type="checkbox"/> Tube Replacement <input type="checkbox"/> Care (Cleaning)			
CPT				
Oxygen				
Misting				
Nebulizer Tx				
Pulse Oximeter				

Are any of the above procedures required for emergency care ? YES NO, IF "YES", specify:

List any procedures the student has been trained to perform _____

List any limitations / precautionary measures that should be considered; e.g. physical education, outdoor activities, transporting, lifting, moving, special devices / equipment : _____

AUTHORIZATION FOR MEDICATION / TREATMENT – Page 2

List any emergency precautions / health emergencies that should be anticipated for this student; e.g. allergy triggers, diabetic reactions, etc.) : _____

There are no extraordinary emergency medical services available at school. Since only CPR and first aid are available until 911 arrive, is this adequate for student survival? YES NO, IF "NO", specify:

Physician's Name (Printed)

Physician's Signature

Physician's Telephone & Fax Numbers

Physician's Office Address

Date Completed

This information will be obtained by School Board District Personnel

PARENTAL PERMISSION FOR MEDICATION / TREATMENT
(TO BE COMPLETED BY THE STUDENT'S PARENT / GUARDIAN)

Student's Name: _____ Date of Birth: _____ Grade: _____
School: _____ Phone #: _____ Fax#: _____

I grant the principal or his / her designee the permission to assist or perform the administration of each medication or treatment / procedure to or for my child during the school day including when he/she is away from school property for official school events.

NOTE:

- **Medications must be supplied in the original container.** Ask the pharmacist to divided the medication into two completely labeled containers, providing one for home and one for school.
- Only medications / treatments authorized by a physician may be administered by school personnel.
- It is your responsibility to notify the school when there is a change in medication / treatment regimen.

Parent / Guardian Name (Printed)

Signature of Parent / Guardian

Date Signed

Home Phone Number

Work Phone Number (Include Ext. if any)

Other numbers where you may be reached during school hours (Include cellular phone and beeper)