Form # 135
Rev. 05/8/15

PHYSICIAN AUTHORIZATION FOR STUDENT MEDICATION

Part I: Must be completed by a Physician/qualified medical provider. Use one form per medication.

Student:_____ Birth date:_____ Date _____

Diagnosis:_____ ICD-9 Dx code:_____

Medication (one per form):_____ Dose prescribed:_____

Route: Oral☐ Liquid☐ Other _____Time to be given_____ (must be specific & match medication label)

PRN ORDERS: If you are ordering medication "***AS NEEDED***", please specify under what conditions the child is to take (i.e. pain):_____ Special instructions:_____

NARCOTICS FOR PAIN MANAGEMENT WILL NOT BE ACCEPTED.

Inhaler/Nebulizer: Medication Name_____ Strength/Dose_____

Amount/# of puffs_____ Schedule (at what time)_____

If you are ordering the Inhaler "*as needed*" please specify under what conditions: (check all that apply)

☐ Shortness of Breath ☐ Coughing ☐ Wheezing ☐ Other_____

The student has been trained and has my permission to self-administer the MDI.

Check One: Student may carry inhaler ☐ **OR** Inhaler to be kept in clinic ☐

Medication side effects: _____

PHYSICIAN AUTHORIZATION

The parent knows of this request and has agreed to provide the supplies needed for the above medication.
Should the child manifest any of the above symptoms that may be caused by the medication, I understand that the parent will be contacted and the school health directives relating to emergency care will be followed.

Physician's Name (Print)	Physician's Signature	Date
License Number	Telephone	Fax Number

Part 2: Must be signed by parent/guardian prior to administration.

Parent/Guardian Permission

I understand that:

- Medication orders, including over-the-counter, are valid for this school year only and need to be renewed at the beginning of each school year.
- Medication, including over-the-counter, must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for supplying medication as needed.
- Medication orders become part of my child's permanent school health record.
- I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed mediation administration as he/she determines appropriate for my child's health and safety.
- I may retrieve the medication from the school at any time; however the medication will be destroyed if it is not picked up within one week following termination of the order or two days beyond the close of school.

I hereby give permission for my child (named above) to receive medication during school hours administered by the nurse or trained principal designee. I understand the School District and School Health Program under take no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release the School District and its agent and employees as well as the School Health Program from any and all liability that may result from my child taking the medication.

Parent/Guardian Name (Print)	Signature	Date
Health Assistant (Print)	Signature	Date
School Nurse (Print)	Signature	Date

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PHYSICIAN AUTHORIZATION FOR EPINEPHRINE INJECTION

Part I: Must be completed by a Physician/qualified medical provider. Use one form per medication.

Student:_____ Birth date:_____ Date _____

Diagnosis/Allergy _____ ICD-9 Dx code:_____

If a food allergy is listed, will a dietary substitution be necessary? No ☐ Yes ☐

EPINEPHRINE Instructions: The student has had a prior severe allergic reaction and must have the following at school:

Epinephrine 0.15mg ☐ **OR** Epinephrine 0.3mg ☐ Repeat injection in _____ minutes **or** ☐ Do not repeat

Check all that apply:

☐The student has been properly trained on the use and administration of epinephrine and will carry epinephrine and self-administer unless unable. **OR**

☐Trained school staff should administer epinephrine

EPINEPHRINE should be administered under the following conditions:

□ Immediately post exposure to the allergen **OR**

□ Administer only if the following reactions occur: (check all that apply):

□ Shortness of Breath/Wheezing □Hives/Rash □Anxiety □Generalized Swelling/Edema

□ Other_____

Medication side effects: _____

PHYSICIAN AUTHORIZATION

The parent knows of this request and has agreed to provide the supplies needed for the above medication. Emergency Services (911) will be called if the student uses or is administered epinephrine so that the proper following treatment can be completed. Should the child manifest any of the above symptoms that may be caused by the medication, I understand that the parent will be contacted and the school health directives relating to emergency care will be followed.

Physician's Name (Print)	Physician's Signature	Date
License Number	Telephone	Fax Number

Part 2: Must be signed by parent/guardian prior to administration.

Parent/Guardian Permission

I understand that:

- Medication orders are valid for this school year only and need to be renewed at the beginning of each school year.
- Medication must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for supplying medication as needed.
- Medication orders become part of my child's permanent school health record.
- I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed mediation administration as he/she determines appropriate for my child's health and safety.
- I may retrieve the medication from the school at any time; however the medication will be destroyed if it is not picked up within one week following termination of the order or the last day of the school year.

I hereby give my permission for my child to self-administer epinephrine during school hours if needed for an allergic reaction. A licensed physician has prescribed this medication and my child has been instructed on its use. I also understand that in the event that my child must self-administer epinephrine emergency services (911) will be called for follow-up treatment. If for any reason my child is unable to inject himself/herself with epinephrine or unable to make the decision himself/herself as to whether epinephrine is needed. I give permission to an adult school staff member who has been trained in emergency epinephrine injection to assist my child in the decision and/or administration of epinephrine.

I understand the School District and School Health Program under take no responsibility for the administration of the medication. I hereby release the School District and its agent and employees as well as the School Health Program from any and all liability that may result from my child taking the medication.

Parent/Guardian Name (Print)	Signature	Date
Health Assistant (Print)	Signature	Date
School Nurse (Print)	Signature	Date