HEALTH CARE PROVIDER AUTHORIZATION AND PARENT CONSENT
FOR MANAGEMENT OF MEDICATIONS AT SCHOOL AND SCHOOL SPONSORED EVENTS

Student:_____Birthdate:_____
School:_____Teacher:_____Grade:_____

HEALTH CARE PROVIDER: Please check all that apply

Diagnosis for which medication is prescribed:
_____
Medication:
_____
Dosage:
_____
Time of day to be given:
_____
Frequency if "as needed":
_____
Method of administration:
- Oral ❑ Liquid ❑ Tablet
- Drops ❑ Eye R/L ❑ Ear R/L ❑Nostril R/L
- ❑ Other:_____

Precautions, reactions, or side effects:
_____
_____

Medication storage & handling:
❑ Routine handling, medications in locked storage and administered by authorized school personnel
❑ Refrigeration

FOR DIAGNOSIS OF ASTHMA/ALLERGIES ONLY

Medication:
_____
Spacer required: ❑ No ❑ Yes

Administration times:(fill in times for only those that apply)
❑ Daily at _____
❑ PRN for s/s asthma/allergy
❑ Other:_____

Administration via: ❑ Inhaler ❑ Nebulizer ❑ Other

Medication dose: ❑ 2 puffs every 4 hours
❑ Other:_____

For Severe Allergy: If the following symptoms occur
❑ Choking ❑ Hives ❑ Skin rash
❑ Swelling (eyes/lips) ❑ Loss of consciousness

Use ❑ Epi-pen Jr. ❑ Epi-pen as directed

If medically necessary:
❑ child to carry, school personnel to administer
❑ child trained to carry and self-administer

Additional orders: _____
_____

AUTHORIZED HEALTH CARE PROVIDER AUTHORIZATION

My signature below provides authorization for the above written orders. I understand that administration of medication to students will be implemented in accordance with state law governing school health services. I understand that administration of medication to students may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. If changes are indicated, I will provide new written authorization (may be faxed).

❑ I have instructed _____ in the proper way to use his/her medication. It is my professional opinion that he/she can carry and use an inhaler and/or Epi-pen by him/herself.

Authorized health care provider:
Signature _____Date_____

Phone number _____Fax_____

OFFICE STAMP

School nurse signature_____Date_____

PARENT/GUARDIAN SIGNATURE PAGE ON BACK OF THIS FORM
LA PÁGINA PARA LA FIRMA DEL PADRE/TUTOR SE ENCUENTRA EN EL DORSO DE ESTE FORMULARIO

HEALTH CARE PROVIDER AUTHORIZATION AND PARENT CONSENT FOR MANAGEMENT OF MEDICATIONS AT SCHOOL AND SCHOOL SPONSORED EVENTS

PARENT OR GUARDIAN CONSENT FOR MANAGEMENT OF MEDICATIONS AT SCHOOL / SCHOOL SPONSORED EVENTS

I, the undersigned parent/guardian of (***student name***): _____ request that the medication stated on the back side of this form, be administered in school to my child in accordance with state laws and regulations. I will:
1. Provide the necessary supplies and equipment.
2. Notify the school nurse if there is any change in my child's health status or attending health care provider.
3. Notify the school nurse immediately and provide new consent for any changes in health care provider's orders.

I authorize the school nurse to communicate with the physician when necessary.

Parent/Guardian signature_____ Print name _____

Date_____

Self-administration

I request that my child be allowed to carry and self administer his/her inhaler and/or Epi-pen. I agree to and do hereby hold the District and its officers, agents, employees, and/or volunteers harmless for any and all claims, demands, causes of actions, liability, damages, expenses, or loss of any sort, including bodily injury or death, because of or arising out of actions of omissions with respect to the administration of the medication(s).

Parent/Guardian signature_____ Print name_____

Date_____

CONSENTIMIENTO DEL PADRE O TUTOR PARA EL MANEJO DE MEDICAMENTOS EN LA ESCUELA/EVENTOS PATROCINADOS POR LA ESCUELA

Yo, cuya firma sigue a continuación, como padre/tutor de (***nombre del estudiante)***:_____, solicito que el medicamento mencionado en el dorso de este documento sea administrado a mi hijo(a) en la escuela, de acuerdo con las leyes y normas estatales. Yo haré lo siguiente:
1. Proveeré los materiales y equipo necesarios.
2. Le notificaré a la enfermera de la escuela si hay algún cambio en la salud de mi hijo(a) o con el proveedor de servicios médicos que lo/la está atendiendo.
3. Inmediatamente le notificaré a la enfermera de la escuela y proveeré un nuevo consentimiento por cualquier cambio en las órdenes del proveedor de servicios médicos.

Autorizo a la enfermera escolar que se comunique con el médico cuando sea necesario.

Firma del padre/tutor _____Nombre en letra de molde_____

Fecha _____

Administración propia de medicamento:

Solicito que se le permita a mi hijo(a) llevar consigo mismo y administrarse así mismo su inhalador y/o Epi-pen. Estoy de acuerdo, y hago al distrito y a sus oficiales, agentes, empleados y/o voluntarios libre de culpas por cualquier reclamo, demandas, motivos de litigio, responsabilidad, daños, gastos o pérdidas de cualquier tipo, incluyendo daños físicos o fallecimiento; debido a/o por actos de omisión con respecto a la administración del medicamento(s).

Firma del padre/tutor_____ Nombre en letra de molde_____

Fecha_____