isla
INTERNATIONAL SPANISH LANGUAGE ACADEMY

Authorization for Administration of Medication

Student's Name _____

DOB_____ Grade _____ Teacher_____ School Year _____

List any known drug allergies/reactions _____ Height _____ Weight _____

Physician Authorization

Medication name _____ Reason for Taking _____

Dosage _____ Route _____ Frequency/Times to Be Given _____

Begin Medication _____ Stop Medication _____
Date Date

Special Instructions:
Does medication require refrigeration? ___ Yes ___ No
Is the medication a controlled substance! ___ Yes ___ No
Is self-medication permitted and recommended for this student? ___ Yes ___ No
I hereby affirm that this student has been instructed in the proper self-administration of the prescribed medication(s)
If asthma inhaler or emergency medication, do you recommend this medication be kept **"on person"** by student ___Yes ___No

Potential Side Effects/Contraindications/Adverse Reactions _____

_____

Prescriber's signature _____ Date _____

Clinic Phone _____ Clinic fax _____

Parent/Guardian Authorization

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to delegate to unlicensed school personnel the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the director, his/her designee, or the school nurse. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate.

_____ _____
Guardian/Parent signature Date

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

_____ _____
Guardian/Parent signature Date