AUTHORIZATION FOR STUDENT MEDICATION

To the Principal of _____ School Date_____

I, the parent/guardian of _____, whose birth date is_____, request the following medication be given to my child during school hours. I release school personnel from any liability involved with administering this medication according to the doctor's instructions below. I understand that this form is valid only with a licensed medical provider's signature. I authorize the school nurse and the medical provider to communicate as needed to ensure the safe administration of the medication. I UNDERSTAND THAT THIS AUTHORIZATION IS IN EFFECT FOR ONE YEAR AND A NEW FORM MUST BE SIGNED BY A MEDICAL PROVIDER EACH SCHOOL YEAR.

_____ _____ _____

Parent Signature Parent's Printed Name Date

In accordance with the request of the parent above I request that the following medication be given to _____ by school personnel during regular school hours:

	Diagnosis	Medication	Dosage	Time
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Only asthma inhalers, epinephrine, and diabetic medications and supplies can be carried by a student at school.
Do you recommend that any of these be kept with the student at all times? If so, which?

_____asthma inhaler
_____epinephrine
_____diabetes medication and supplies

Has the student been trained to self-administer the medication and are they capable of doing this safely? No Yes

Potential side effects of these medications the school staff needs to be aware of: _____
_____

Additional instructions to the school: _____
_____

Note: If a request is being made to administer Glucagon to a diabetic student in an emergency low- blood sugar situation, an additional, specific form, the Utah State Administration of Glucagon form, must be signed by the parent and physician and kept on file at the school.

_____ _____ _____

Physician Signature Physician's Printed Name Date

_____ _____ _____ _____

Signature of Principal Date Signature of School Nurse Date

Signature of staff members assigned to administer the above medications:

1._____ 2._____ Date _____