MEDICATION AND/OR NURSING PROCEDURE AUTHORIZATION FORM

Medication will be administered in the school ONLY when it is necessary for a student to remain in school. Medication should be sent to school with or for a student **ONLY WHEN IT IS AN ABSOLUTE NECESSITY.**

The purpose of this policy is to ensure that students receive necessary medication according to their physician's orders and to ensure maximum safety for all concerned. Please understand that your signature on this form authorizes other school personnel to supervise your child with self-administration of medication.

Should you be asked to complete one of these forms, please read the form thoroughly and respond to ALL items. Contact the school health assistant if you have any questions. THANK YOU.

One form must be filled out **ANNUALLY** for **EACH** medication **PRESCRIPTION AND NON-PRESCRIPTION** or **NURSING PROCEDURE**.

PHYSICIAN'S STATEMENT:

Date: _____ **School:** Public Academy for Performing Arts **2021-2022**

Student's Name: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____ Dosage: _____

Time of Administration: _____ Duration of Administration: _____

Special Instructions for Medication/Nursing Procedure: _____

_____

_____

_____

_____ Student may only self-administer under direct supervision of a designated, trained staff person. Medication will be kept in a locked medication safe.

Physician's Signature: _____ Phone: _____

Physician's Name (Print): _____

PARENT/GUARDIAN STATEMENT:

I/We, the parent(s) of _____ (Student's Name) hereby request that this medication be given to my/our child according to the physician's instructions.

I/WE agree to furnish the necessary medication in a pharmacy/original labeled container, to provide replacement medication as necessary, and to provide a new physician's statement if there is ANY change in the medication, dosage, administration time, administration route, or special instructions regarding the medication. I/WE understand that other designated personnel (other than the school nurse) may supervise the child with self-administration of medication**.**

Parent's/ Guardian's Signature: _____ Date: _____