SCHOOL MEDICATION AUTHORIZATION FORM

Utah Department of Health, Ogden School District - In Accordance with UCA 53G-9-501

Do not use this form for inhalers, epinephrine, insulin, Glucagon, or seizure rescue medication

Date:

Picture:

STUDENT INFORMATION

Student:	School:	DOB:	Grade:
Parent:	Phone:		Email:
Prescriber Name:	Phone:		Fax:

Parent: complete the above section, read and sign below, obtain signature from Health Care Provider and return to school nurse.

As parent/guardian I request the medication(s) listed below be given to my student during regular school hours.

☐ I understand medication will be administered by trained school employee volunteers.
☐ I understand a new medication authorization form will be required each school year, and whenever there is a dosage change.
☐ I understand parent or guardian is responsible for maintaining necessary supplies, medications, and equipment.
☐ I understand prescription medication must be transported to and from school by an adult*.
☐ I understand all medication, both prescription and over-the-counter, must be in the current original pharmacy container and label, with the child's name, medication name, administration time, dosage, and health care provider's name.
☐ I understand over-the-counter medication must be in the original manufacture container.
☐ I understand the information contained in this order will be shared with school staff on a need-to-know basis.
☐ I understand it is my responsibility to notify the school nurse of any change in my student's health status, care or medication order.

I give permission for my child's healthcare provider to share information with the school nurse for the completion of this order.

Parent Signature: **Date:**

MEDICATION INFORMATION **MUST USE SEPARATE FORM FOR EACH MEDICATION**

If a request is being made for school staff to administer asthma medication, epinephrine auto-injector, diabetes medication, or seizure rescue medication, an additional specific form(s) will be required, and must be signed by the parent and physician, and kept on file at the school. These supplemental forms will also be required for students who carry and self-administer asthma medication, epinephrine auto-injectors, and diabetes medications. Seizure rescue medication cannot be carried by a student.

Name of Medication	Indication	Dose	Route	Time or PRN Indications	Side Effects

PHYSICIAN SIGNATURE-*This form must be signed by prescriber to be valid, and can only be signed by an MD/DO; Nurse Practitioner, Certified Physician's Assistant or a provider with prescriptive practice.*

The above named student is under my care. It is medically necessary for medication administration while student is under the control of the school.

☐ **It is medically appropriate for the student to self-carry*** this medication, when able and appropriate, and be in possession of this medication and supplies at all times (see statement above under Medication Information). This student has been trained to self-administer the medication and is capable of doing this safely.

☐ **It is not medically appropriate to carry and self-administer this medication**. Please have the appropriate/designated school personnel maintain this student's medication for use if needed.

Physician Name:	Physician Signature:	Date:

For School Office Use

Medication will be kept: ☐ In the office ☐ In the classroom ☐ With Student *(single-day dose only)*

☐ Copy of this form sent to District Nurse

☐ School staff authorized to administer medication (list):

District Nurse Signature:	**Date:**
School Principal Signature:	**Date:**