ST.MARYS AREA SCHOOL DISTRICT

____________ School Year

AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

SMAHS	SMAMS	SSMSES	FOX	BV
P: 781-2130	*P: 781-2150*	P: 834-3021	P: 885-8076	P: 781-2156
F: 781-6308	F: 781-2191	F: 834-7814	F: 885-6331	F: 781-2157

Student's name: Grade:

Medical condition:

Medication: Dosage: Route:

Time(s) to be administered at school:

Lunchtime ☐ PRN ☐ _______________ Other:______________

On a 2 hour delay schedule, administer medication: [ ] At prescribed time as above

[ ] At adjusted time: ________________________ or [ ] Medication should not be administered

Student is able to self administer / carry Emergency Medication with them: **YES** **NO**

(applicable for inhalers and EpiPens only)

Health Care Provider: (Physician, Physician Assistant, Nurse Practitioner)

Name: ____

Health Care Provider's Signature: ________________________________Date:___________

Telephone:__________________________ Fax: __________________________________

I am fully aware that my child has been placed on medication to be given during the school day as prescribed by my child's health care provider.

Parent/Guardian's Signature: ___________________________________Date: __________

Parent/Guardian's Printed Name: ________________________Telephone: ___________________

If your child requires emergency medication, when was the last time they had a reaction requiring emergency treatment or administration of emergency medications?

School Nurse's Signature: _______________________________________Date: ____________

ALL MEDICATIONS MUST BE TRANSPORTED TO SCHOOL BY A RESPONSIBLE ADULT

*__All medication must be in the original pharmacy container or over-the-counter packaging. Students may not transport medication to and from school. Parent consent and physician orders expire at the end of each school year. All medication orders must be renewed annually__.