## **Authorization to Administer Medication in Program**

Student Name:	DOB:	Grade:
Last Name, First Name		
Part I		
Dear Parent or Healthcare Provider,		
When considered medically necessary, students may receive	medications and treatment	s as ordered by a licensed
healthcare provider, during the program day. Please comple		•
Orders are valid for one program year.	· ·	
• NO MEDICATION OR TREATMENT may be given by the p	rogram nurse or designee ur	ntil this form is completed
and properly labeled medication is received. THIS INCLU	DES OVER THE COUNTER M	EDICATIONS SUCH AS
TYLENOL, MOTRIN, AND COUGH DROPS.		
A physician signature and a parent signature must be on		
All mediations must be stored in their original containers		•
labels will include the student's name, does, frequency,	oute, time of administration	n of the medication.
Part II		
Dear Healthcare Provider,		
The parent initiates this request and has the responsibility fo	r supplying medication and,	or treatment supplies. Should
the student display any adverse reactions, the parent will be	contacted immediately, em	ergency care will be provided as
needed and the medication/treatment discontinued. The pa	rent will be responsible for	contacting you for follow-up
care as you deem necessary. Please sign below, acknowledg		procedure for management of
side effects to prescribed medications or treatments. Thank	you for your assistance.	
Part III  Medication Treatment #1:  Name of Drug/Treatment		
DosageRouteFrequency_		(include times and duration)
Medication form pill/capsule inhalere		
Known adverse reactions/side effects		
Prescribed treatment for side effects, if other than as outline		
Medication Treatment #2:		
Name of Drug/Treatment		
Dosage Route Frequency		
Medication form pill/capsule inhalere		
Known adverse reactions/side effects		
Prescribed treatment for side effects, if other than as outline	d above	
Medication Treatment #3:		
Name of Drug/Treatment		
DosageRouteFrequency_		(include times and duration)
Medication form pill/capsule inhaler		
Known adverse reactions/side effects		
Prescribed treatment for side effects, if other than as outline		

## Part IV

Parent Permission:

I hereby give permission for my child to receive the above medications/treatments during program hours. I understand that medications may be administered by the program registered nurse or designee. This designee may be a non-medical person. If a treatment requires a medical or nursing assessment prior to administration, and a licensed medical person is not available, the medication and/or treatment will not be given. This medication and/or treatment is considered a medical necessity and ordered by a licensed healthcare provider. I hereby release the FAUS District, its agents and employees from any and all liability that may result from my child receiving this medication and/or treatment.

Parent/Guardian Signature	Date	Healthcare Provider Signature	Date
Parent/Guardian Name (Print)	Phone #	Healthcare Provider Name (Print)	Phone #
	Do Not Write Belo	w This Line-Program Use Only	
Comments:			
Medication/Treatment Received	Approved by:	(Pro	ogram Nurco Signaturo
		cured in locked cabinet:Yes No	ogram Nurse Signature)
· · · · · · · · · · · · · · · · · · ·		(Procured in locked cabinet:Yes No	ogram Nurse Signature)
Date:Amount: Logged in Medical Administration E		(Pro cured in locked cabinet: Yes No	ogram Nurse Signature)
		(Pro cured in locked cabinet: Yes No	ogram Nurse Signature)
Date:Amount: Logged in Medical Administration E	Approved by: Book:Yes No Sec	(Pro cured in locked cabinet: Yes No	ogram Nurse Signature)
Date:Amount: Logged in Medical Administration E		(Pro	ogram Nurse Signature)