Authorization for Medication/Procedure
To Be Administered At School & Field Trips

Part A
Parent to Complete

Name of Student: _____Date of Birth:_____Grade/Teacher: _____

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school as indicated by my child's physician accordingly below. I understand that I must provide any prescribed medication in its original labeled container.

I also acknowledge the need and give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question, including communication concerning: 1. the prescription or treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube); 2. implementation of the treatment in school (e.g., questions regarding safety concerns, infection control issues, or modifications int he treatment order related to the school setting or student's academic schedule); 3. student outcomes from the treatment (w.g., questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom); 4. and other pertinent issues related to the student's diagnosis, condition, or treatment.

_____ _____ _____
Parent Signature | Parent (Printed Name) | Today's Date

Part B
Physician to Complete

Current Diagnosis(es): _____ _____ _____

Physician Medication and/or Treatment Orders: (please specify)

Medication/Treatment	Dosage	Time/Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special Instructions:_____

_____

_____ _____ _____
Physician Signature | Physician (Printed Name) | Today's Date

_____
Physician Phone Number