

Coulee-Hartline School District Medication Authorization

For Oral and Emergency Injected Medication Administration at School

Student Name: _____ Birth Date: _____

School: Coulee-Hartline School District Grade: _____

LICENSED HEALTH PROFESSIONAL (LHP)

Complete this section using one form for each medication

Diagnosis or reason for medication: _____

Severity of the problem: mild moderate severe

Activity modifications or restrictions: _____

Name of Medication	Dosage	Method of administration	Time to be given or frequency if PRN

If given PRN, describe indications: _____

For Epi-Pens, describe signs or symptoms when to use: _____

Can the student travel on field trips > 30 minutes away from emergency medical response? Yes No

Possible side effects of medication: _____

For Inhalers, Epi-Pens, & Benadryl only:

Student is capable of **self-administration** of medication and has received instruction in the correct and responsible way to use the medication: Yes No

Student can carry the medication on their person responsibly: Yes No

I request and authorize that the above-named student be administered or self-administer this oral medication according to the instructions indicated above from ___/___/___ to ___/___/___ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

Date of Signature

Licensed Health Professional

Phone / FAX

Name (Print)

PARENT or GUARDIAN

To complete this section

I request and authorize the school to administer medication to the above student in accordance with the LHP's instructions for the period from ___/___/___ to ___/___/___ (not to exceed the current school year). I understand that information about this medication and health problem will be shared with school staff that need to know.

For Inhalers, Epi-Pens, & Benadryl only:

I give my permission for my child to carry this medication with them at school: Yes No

I give my permission for my child to self-administer medication: Yes No

If I give permission for self-administration or for my child to carry medication, I understand and agree that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the student.

Date of Signature

Parent/Guardian Signature

Home Phone

Work or Cell Phone