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 EpiPens, 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:______________________________

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.

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*

 Reviewed by RN/LPN: ______________________________ on ___/___/___