HARTLAND CONSOLIDATED SCHOOLS

Medication Authorization Form

"Medication" shall include prescriptions, over-the-counter medication and other remedies per HCS Board policy #5330.

STUDENT NAME _____ DATE of BIRTH _____

SCHOOL _____ GRADE _____ SCHOOL YEAR _____

TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

Medication Name	Dose	Time to be administered	form/route	side effects
1.				
2.				
3.				

List minimal frequency between doses if PRN/as needed:_____

If PRN, list symptoms/condition under which medication is to be given: _____

SPECIAL INSTRUCTIONS: _____

Epi-Pen Use: *This student is capable & responsible for self-carrying & administering:* Yes____ No___

Inhaler Use: *This student may carry their inhaler & is capable of self-administration:* Yes____ No___

Start Date _____ End Date _____

Physician's Signature _____ Date_____

Physician's Printed Name _____

Physican's Phone & Fax number_____

Physican's Address _____

TO BE COMPLETED BY PARENT/GUARDIAN

I request and give permission for (name of child)_____ to receive the above medication(s)/treatment at school according to standard school district policy and for the physician/staff and school district staff to share information needed to assist my child with medication needs. The school requires parent/guardian to bring medication in the original container.

Parent Signature _____ Phone # _____

Date _____

Revised 8/23/16