

JLCD-E2 - Administration of Medication to Students Authorization Form

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To be completed by the child's Health Care Provider and Parent/Guardian.

Please complete this form to allow the school nurse or designated school staff member to administer the named medication. All medication must be brought to school by an adult and will be kept in the school nurse's office. The medication must come in the original container with the student's name and prescription instructions labeled. This must be renewed annually or updated with changes to prescription.

School Year: _____ to _____

Student Information

Student Name: _____ D.O.B. _____
School: _____ Grade: _____ Teacher: _____
List Any Known drug allergies/reactions: _____
Height: _____ Weight: _____

Physician - Prescriber Order/Authorization

Provider Name: _____ Office phone #: _____
Office Address: _____
Medication Name: _____ Reason: _____
Dosage/Route: _____ Frequency: _____
Begin Medication: _____ Stop Medication: _____
Potential Side Effects/Contradictions/Reactions: _____
When will the student be reevaluated? _____

Special Instructions:

Does the medication require refrigeration?	Yes	No
Is the medication a controlled substance?	Yes	No

Physician Signature

Date

Fax #

PARENT/GUARDIAN AUTHORIZATION

As a parent/guardian I request the designated school personnel to administer the above medication at school according to district policy. Information regarding my child's medication may be shared with appropriate school personnel. I authorize the school nurse to communicate with the health care provider.

Parent/Guardian Signature

Date

Home Phone #

Cell #

Work #

5/14

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