CENTRAL VALLEY
SCHOOL DISTRICT #356

Authorization for Administration of Medication at School

Student Name:_____ Birthdate: _____

School:_____ Grade: _____

This portion to be Completed by Licensed Health Professional (LHP) with Prescriptive Authority

Name of Medication	Dosage	Methods of Administration	Time of day to be taken

Diagnosis: _____

If given 'as needed' (prn), specify the length of time between doses: _____

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

Use the *School Asthma Plan and Medication Orders* form for all inhaler and nebulizer orders and the *Severe Allergic Reaction Plan & Medications Orders* form for all injectable emergency medication orders.

I request and authorize that the above named student be administered the above identified oral medication in accordance with the instructions indicated above from _____ to _____ (Not to exceed current school year), as there exists a valid health reason that makes administration of the medication advisable during school hours.

Date of Signature: _____ Licensed Health Professional's Signature: _____

Telephone #:_____ Fax #:_____ Print Name: _____

This Portion to be Completed by the Parent/Guardian

I have reviewed the parent information regarding medication at school and request/authorize the school to administer medication to my student in accordance with the LHP's instructions for the period from _____ to _____ (not to exceed current school year). District Policy, 3416 AP, states that due to the schedule and other responsibilities, it is possible for a dosage(s) to be delayed or missed.

Date of Signature: _____ Parent/Guardian Signature: _____

Home phone #: _____ Work/cell phone #: _____

This record must be kept for a period of 8 years