Medication Administration Authorization Form

Student: _____ DOB: _____ Date: _____

School/ISD: _____ Grade: _____ Teacher: _____

Routine and PRN Medications

Medication Name	Medication Dose	Medication Administration Time at School	Medication Route	Beginning and Ending Date
				/
				/
				/

Epi-Pen Self-Administration Authorization – *to be completed by Health Care Provider*

The above student needs to carry a prescription Epi- Pen with him/her. This student has been instructed in the proper use of the Epi-Pen and fully understands how to administer this medication. **This student is / is not (circle one) capable of administering their own medication, both on school grounds and at school related activities.** Any changes to this medication, dosage or recommended regimen will be accompanied by an updated medication administration authorization form.

Will student keep a back up Epi-Pen in clinic? Yes _____ No _____

Inhaler Self-Administration Authorization – *to be completed by Health Care Provider*

The above student needs to carry a prescription Inhaler with him/her. This student has been instructed in the proper use of the Inhaler and fully understands how to administer this medication. **This student is / is not (circle one) capable of administering their own medication, both on school grounds and at school related activities.** Any changes to this medication, dosage or recommended regimen will be accompanied by an updated medication administration authorization form.

Will student keep a back up Inhaler in clinic? Yes _____ No _____

Physician/N.P. Name: _____ **Phone Number:** _____

Physician/N.P. Signature: _____ **Date:** _____

****

I give permission as the parent/guardian of the above student to receive the above mentioned medication(s) at school according to school policy.

Parent/Guardian: _____ **Date:** _____

Parent/Guardian Signature: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____