



Calvin Christian School • Authorization for Administration of Medication 2011-2012

Physician and Parent Signature Required Below.

(Photo)

Parents/guardians asking school staff to give medications to their child must provide written permission each school year that has been signed by the child's licensed health care provider **and** the parent/guardian. The medication must be provided in the original, labeled container.

PHYSICIAN/LICENSED PRESCRIBER'S ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL—To be completed by physician/ licensed prescriber.				
Medical Condition	Medication. Please specify medication.	Dose	Route	Frequency
1.				
2.				
3.				
4. ___ This student uses inhaled medication, and has been instructed on proper use, side effects, and safeguards regarding the medication. The student is authorized to keep this medication with them during the school day and to use the medication as needed according to the licensed prescriber's instructions.				
Physician/Licensed Prescriber Signature (required): _____		Date: _____		
Print Name of Prescriber: _____		Clinic Name: _____		
Phone: _____		Fax: _____		

Student: _____ **Date of Birth:** _____ **Grade** _____

All authorizations expire at the end of the school year or following the summer school session.

<u>Parent/ Guardian Authorization</u>	
<ol style="list-style-type: none"> 1. I request that the above medication/s be given during school hours as ordered by my child's physician/licensed prescriber. 2. I request that the medications be given on field trips as prescribed. <input type="checkbox"/> Yes <input type="checkbox"/> No 3. I will notify the school if medication is stopped. 4. I give permission for the medication/s to be given by school personnel as delegated, trained, and supervised by the school nurse. 5. Self-carry inhalers only: My student's physician/licensed care provider and I agree that my child should self-carry and self-administer his/her inhaler. <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Legally I may refuse to sign the authorization to administer medication form. If I refuse to sign, we will not be able to administer the medication. 7. This consent may be revoked at any time by sending a written notice to the licensed school nurse. 	
Parent/Guardian Signature _____	Date _____

<u>Permission for Release of Information</u>	
<ol style="list-style-type: none"> 1. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical conditions/s and the action of the medication/s in order to provide for your child's health and safety needs at school.. 2. I give permission for the school nurse to contact my child's physician/licensed prescriber with questions about the above listed medication/s or medical condition/s being treated by medication/s. 	
Parent/Guardian Signature _____	Date _____

For Faxed Orders Return to:

_____ School: _____ Phone: _____ Fax: _____

RN, Licensed School Nurse