DEPOSIT CENTRAL SCHOOL DISTRICT
PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child ______________________ DOB __________ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.

Signature (Parent or Guardian): ______________________________

Telephone: Home ______________ Work ______________ Date __________

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student: ______________________________ DOB __________

Diagnosis: ______________________________

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: ______________________________

Possible Side Effects and Adverse Reactions (if any): ______________________________

PLEASE CHECK ONE:

☐ **Students in 4th & 5th grade only:** I deem this child to be sufficiently knowledgeable for the school nurse to begin teaching the associated disease process and administration of the above medication with the intent that this child will, when the nurse deems appropriate, be **self-directed,** thus allowing the student to administer their own medication(s) in the presence of the school nurse, or other designated persons in the case of the absence of the school nurse, during school hours and/or functions as appropriate, including field trips.

☐ **Students in 4th & 5th grade only:** I deem this child to be sufficiently knowledgeable of their disease process to **self-carry** their medication with them at all times to use as ordered.

☐ I deem this child to be **non self-directed** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Physician's Signature: ______________________________ Date: __________

Address: ______________________________ Phone: __________

- **Medication must be in original pharmacy labeled container with specific orders and name of medication.**
- **Medication and refills must be brought to school by parent or guardian.**

Plan reviewed with parent(s)/guardian(s):

Parent Signature: ______________________________ Date: __________