DaVinci Academy of Arts+Science

SCHOOL YEAR: _____

MEDICATION AUTHORIZATION

Please note that the Parent/Guardian AND a Licensed Healthcare Professional must provide written permission for School Personnel to administer medication(s) every school year.

Student: _____ DOB: _____ Grade: _____

PHYSICIAN/LICENSED PROVIDER TO COMPLETE

MEDICATIONS REQUIRED DURING SCHOOL HOURS

All authorizations expire at the end of the school year.

Diagnosis	Medication	Dose	Time	Route

Inhaler - Please include Asthma Action Plan:

☐ Student may carry/self-administer his/her inhaler according to the Licensed Prescriber's instructions. The student has been instructed on proper use, side effects, and safeguards regarding medication.

Epinephrine - Please include Anaphylaxis Action Plan:

☐ Student may carry/self-administer EpiPen according to the Licensed Prescriber's instructions. The student has been instructed on proper use, side effects, and safeguards regarding this medication.

Other

☐ Student may carry/self-administer _____ (medication). The student has been instructed on proper use, side effects, and safeguards regarding this medication.

_____ _____ _____

Signature of Provider **Printed name of Provider** **Date**

_____ _____ _____

Clinic Name **Clinic Phone Number** **Clinic Fax Number**

Parent/Guardian Medication Authorization

1. I request the medication listed be given during school hours as ordered by this student's licensed health care provider. Only daily medications and those for life threatening/emergency conditions will be sent on field trips.
2. I will provide the school with physician/licensed prescriber authorization for any change in medication(s) and/or treatment(s).
3. I give permission to designated school staff to administer the above medication(s) and/or perform treatment(s). I release the school personnel from any liability in the administration of this medication(s) or treatment.
4. I understand that school Health Staff cannot administer the medication(s)/treatment(s)/procedure(s) indicated on this form without authorization from both my student's physician/licensed prescriber and guardian/parent.
5. I give permission for Health Office staff to consult with this student's Licensed Health Care Provider regarding questions about the above medical condition(s) and medication/procedure being used to treat the condition.
6. I give permission for the Health Office staff to communicate as needed with school staff about my student's health condition(s) and the action of the medication and/or treatment.

Parent/Guardian Signature: _____Date:_____

Parent/Guardian name (please print): _____ Telephone #: _____

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