AUTHORIZATION FOR STUDENT MEDICATION

| To the Principal of | | School | Date | |
|--|---|---|--|---|
| I, the parent/guardian of | yen to my chi g this medica ensed medic needed to en TION IS IN | ild during school hours tion according to the do al provider's signature. It is safe administres the safe administres. EFFECT FOR ONE Y | I release school per octor's instructions by I authorize the schoration of the medicate EAR AND A NEW | ersonnel from any liability below. I understand that this bool nurse and the medical cion. I UNDERSTAND |
| Parent Signature | | Parent's Pri | nted Name | Date |
| In accordance with the requ | | | | ication be given to |
| Diagnosis | - | Medication | Dosage | Time |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| Only asthma inhalers, epine diabetic medications and a be carried by a student at Do you recommend that a kept with the student at al Has the student been trained medication and are they c Potential side effects of the the school staff needs to | supplies can school. .ny of these b l times? If so l to self-adm apable of doi | oe o, which? inister the ing this safely? | epine | na inhaler ephrine etes medication and supplies Yes |
| Additional instructions to the | ne school: | | | |
| Note: If a request is being situation, an additional, speaparent and physician and ke | cific form, th | e Utah State Administr | | emergency low- blood sugar orm, must be signed by the |
| Physician Signature | | Physician's Prin | nted Name | Date |
| Signature of Principal | Date | Signature of Scho | ool Nurse | Date |
| Signature of staff members | assigned to a | administer the above me | edications: | |
| 1. | | 2. | Т | Date |