NORTHWEST ASTHMA & ALLERGY CENTER

MEDICATION SCHOOL AUTHORIZATION

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

Name of medicine:
Diagnosis for which medication is given:
Form and dose:
If medication is to be given DAILY, at what time?
If the medicine is to be given "WHEN NEEDED," describe indications:
How soon can it be repeated?
Patient ☐ may ☐ may not keep medications on person and self-administer.
Side effects of the drug (if any) to be expected:
Length of time this authorization is valid: ***x 1 year***
Physician's Signature: Date:

PARENT'S PERMISSION

I request that my child be allowed to take medication as described above. The medication is to be furnished by me in the original container labeled by the pharmacy or physician with the name of the medicine, the amount to be taken, and the time of day to be taken. The physician's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered following the physician's directions. In case of necessity, the school district may discontinue medication administration with proper advance notice. I am the parent or the legal guardian of the child named.

Signature of parent or guardian: _____ Date: _____

Emergency daytime phone: _____

School Nurse approval: _____ Date: _____