PARENT AND PHYSICIAN'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION IN SCHOOL AND DURING SCHOOL ACTIVITIES
REFERRAL FOR SKILLED NURSING SERVICES

A. To be completed by the parent or guardian:

I request that my student ______________________________ 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*. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including while on field trips.

Signature (Parent or Guardian): ____

Telephone: Home: __________________________ Work: ________________________ Date: __________

B. To be completed by Provider:

☐ **Per MEDICAID requirements, frequency & duration as indicated "per" IEP when appropriate.**

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

Name of Student: ____ DOB**:**________________

Diagnosis: ____ ICD-10 Code: ________________

Name of Medication: ____

Prescribed Dosage, Frequency and Route of Administration: ____

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Time to Be Taken During School Hours: ____

Start Date: _________________________________ End Date: ____________________________________

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

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____

Physician/NP/PA Signature: ____ Date: ________________

Address: ______________________________________ Phone: __________ Fax: ________________

License number: ___________________________ NPI number: _________________________________

* 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, guardian or responsible adult.