STERLING SCHOOLS
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name:______________________________________ Birth Date:__________

School:____ Grade:______________

THIS PORTION TO BE COMPLETED BY PHYSICIAN/DENTIST/PROVIDER

Name of Medication	Dosage	Route	Time of Day
____________________	__________	__________	__________

If given prn specify the length of time between doses ______________________________

Inhalers:____

Indicate if student must carry on his/her person (above 6th grade) Yes_____ No_____
(Parents are recommended to maintain a backup inhaler in the office for an emergency)

It is safe for unlicensed staff provide this student this medication Yes____ No_____

Emergency procedure in case of serious side effects______________________________

I request and authorize that the above-named student by administered/provided the above identified medication in accordance with the instructions indicated above from________________ to ________________ (not to exceed the current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

________________ ______________________________________
Date of Signature *Physician/Dentist/Provider Signature*

________________ Name:______________________________
Telephone Number *(Print or Type)*

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, route, and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authori_e the school to give medication to my student in accordance with the health care provider's instructions written above. I understand that unlicensed staff may be assigned to provide medication to my student, and I accept ultimate responsibility for monitoring the effects of this medication.

Permission to carry inhaler Yes____ No____ Contract Signed Yes____ No____

__________ ______________________________ Phone #____________ ____________
Date *Parent/Guardian Caretaker Signature* *Home* *Work*