JORDAN SCHOOL DISTRICT NURSING SERVICES
SCHOOL MEDICATION AUTHORIZATION FORM

School Year: ________________

Student's Name: ___________________________________ **Birth Date:** ____________________

School: ________________________________ **Grade:** ________ **Teacher:** _______________________

TO BE COMPLETED BY HEALTHCARE PROVIDER:

This order can only be signed by Physician (MD, DO), Dentist, Nurse Practitioner (NP, FNP, PNP, APRN/PP), or Certified Physician's Assistant. **Utah Law (53a-11-501) requires that medication administered during school hours must be medically necessary.**

*** ONLY ONE MEDICATION PER FORM ***

Diagnosis: ____________________________________

Medication: ___________________________________ **Duration To Be Given:** _________________________

Dosage: _________________________ **Time:** ______________ **Route:** ________________________________

Reportable Adverse Reactions/Side Effects: ____

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Special Instructions: ____

MEDICATION SELF-ADMINISTRATION AUTHORIZATION

*According to Utah State Law Students are **only** allowed to carry and self-administer epinephrine auto injectors, asthma inhalers and insulin. The above named student is under my care and has been trained in self-administration of the following medication, and is capable of carrying and self-administering the indicated medication:*

[ ] Auto-Injectable Epinephrine [ ] Inhaler [ ] Insulin

Name of Healthcare Provider: _______________________________________ **Phone:** _________________________

Healthcare Provider Signature: ______________________________________ **Date:** __________________________

PARENTAL RESPONSIBILITIES:

- Parent must furnish the school with a completed *School Medication Authorization Form* prior to any medications being administered by school personnel.
- The medication must be delivered to the school by the parent in the original container, labeled with the child's name, medication, time, dosage, and healthcare provider's name.
- All medication must be delivered to the school by an adult and picked up by an adult within two (2) weeks of last dose given.
- If there is a change in the medication or medication dosage, a new *School Medication Authorization Form* must be completed before school personnel can administer the new medication or new medication dose.

I UNDERSTAND THAT BY SIGNING THIS FORM:

- I am giving permission to the school personnel to contact the healthcare provider regarding this medication.
- I am giving permission for this medication to be administered by someone other than a licensed nurse who has been appointed by the school administrator.
- *(Except in the case of glucagon or auto-injectable epinephrine)*, school personnel CANNOT administer:
  - the 1st dose of a new medication, OR
  - the 1st dose of a *dosage change* of any medication.

Parent Signature: _______________________ **Date:** _____________ **Emergency Phone Number:** ______________

District Nurses Signature: ______________________________

White – School Copy Yellow – District Nurse Copy Pink - Parent Copy Revised 9/2008