# AUTHORIZATION FOR MEDICATION/PROCEDURE TO BE ADMINISTERED AT SCHOOL & FIELD TRIPS

## Part A
## *Parent to Complete*

Name of Student: _____ Date of Birth: _____ Grade/Teacher: _____

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school as indicated by my child's physician accordingly below. I understand that I must provide any prescribed medication in its original labeled container.

I also acknowledge the need and give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question, including communication concerning: 1. the prescription or treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube); 2. implementation of the treatment in school (e.g., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule); 3. student outcomes from the treatment (e.g., questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom); 4. and other pertinent issues related to the student's diagnosis, condition, or treatment.

| _____ | _____ | _____ |
|---|---|---|
| Parent Signature | Parent (Printed Name) | Today's Date |

## Part B
## *Physician to Complete*

Current Diagnosis(es): _____ _____ _____

**PHYSICIAN MEDICATION AND/OR TREATMENT ORDERS:** (please specify)

| Medication / Treatment | Dosage | Time / Frequency |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Special Instructions: _____

_____

| _____ | _____ | _____ |
|---|---|---|
| Physician Signature | Physician (Printed Name) | Today's Date |

_____
Physician Phone Number

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