GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

School Health Program
AUTHORIZATION FOR MEDICATION ADMINISTRATION FORM

NAME OF STUDENT: _____ DOB: _____

SCHOOL: _____ SOC SEC. # _____ Grade: _____

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this action.

I hereby request and authorize the School Nurse/Licensed Practical Nurse/Trained Certified DCPS Personnel to administer prescribed medication as directed by the physician to _____
STUDENT'S NAME

I have read the procedures on the reverse side of this form and agree to assume the responsibilities as required.

This medication is a □ new or □ renewal prescription. If new prescription, enter date and time the first dose was given at home.

Date: _____ Time: _____ A.M/P.M

_____ _____
SIGNATURE OF PARENT/GUARDIAN RELATIONSHIP

_____ _____
PLEASE PRINT NAME DATE

PLEASE TAKE THIS FORM TO STUDENTS PHYSICIAN FOR COMPLETION

PART II: PHYSICIAN'S MEDICATION AUTHORIZATION ORDER

Physician: Please complete and sign this action. □ Original □ Renewal □ Change

NAME Of STUDENT: _____ DOB: _____

ADDRESS: _____ TEL. NO.: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSE: _____

TIME & CIRCUMSTANCES OF ADMINISTRATION AT SCHOOL: _____

EXPECTED DURATION OF ADMINISTRATION: _____

CAN REACTION BE EXPECTED? Yes No If yes, please describe: _____

_____

If any change, please advise in writing immediately.

_____ _____
PHYSICIAN'S SIGNATURE ADDRESS

_____ _____ _____
PLEASE PRINT NAME TELEPHONE NO. DATE

_____ _____
SCHOOL NURSE DCPS TRAINED STAFF