Date:

Dear Parents/Guardian,

Medical Authorization to Administer Medication or Dietary Supplement to Student and Authorization for Release of Health Information

Health Care Provider Order for School to Administer Medication (prescribed) or Dietary Supplement.

I request the following student be given medication at school because I believe there exists a valid health reason which necessitates medication administration during the school day.

This Order Good for School Year: 2023 - 2024

Student Name _____ Birthdate _____

Medication #1 _____ Time to be administered at school _____

Condition being treated (Include ICD 10 Code) _____ Dosage and mode of administration. _____

Side Effect to be expected, if any. (What emergency measures should be taken if this occurs?) _____

Medication #2 _____ Time to be administered at school _____

Condition being treated (Include ICD 10 Code) _____ Dosage and mode of administration. _____

Side Effect to be expected, if any. (What emergency measures should be taken if this occurs?) _____

Other medications the School should be aware of. _____

Health Care Provider Name (Printed) _____ Health Care Provider Signature _____

Address _____ Date _____

Telephone _____ Fax _____ Email _____

Parent agrees that the school nurse may contact physician with questions regarding the above medication and possible side effects as needed and the exchange of medically necessary information between both Health Care professionals.

Parent Signature and Printed Name _____ Date _____

School Nurse Signature _____ Date _____

School Nurse: | Melina Mirabal, RN, BSN | Phone No. | 623-445-7610 | Fax No. | 623-445-7680 |

02/25/22 jd