

NOVA SCHOOL

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student's Name _____ Birth date _____ Grade _____

Form required for all prescriptions and/or over-the-counter medications to be administered at school or on a NOVA-related field trip.

THIS PORTION TO BE COMPLETED AND SIGNED BY THE LICENSED HEALTH PROFESSIONAL, IF IT IS NECESSARY TO DISPENSE MEDICATION DURING SCHOOL HOURS.

Name of Medication _____ Dosage _____ Methods of Administration _____ Time of Day to be Taken _____

If prn, specify the length of time between doses: _____

Reason for medication to be given during school hours: _____

Permission to carry: INHALER: YES _____ NO _____ EpiPen: YES _____ NO _____
INSULIN: YES _____ NO _____ (Insulin injection may not be delegated to unlicensed staff.)

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above from _____ to _____. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by trained school personnel.

Date of Signature _____ Signature of Licensed Health Professional _____ Name (Please print or type) _____
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Phone FAX Address City Zip Code

THIS PORTION TO BE COMPLETED AND SIGNED BY THE PARENT/GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above-identified student. I request and authorize the school to administer the above-identified medication to the above-identified student in accordance with the prescription or instructions from a licensed health professional.

Medication must be supplied to the school in the original container, and the written authorization must match exactly the information on the container.

I understand and agree that because of schedule and other responsibilities, a dosage or dosages may be delayed or missed. Permission granted to exchange medication information with the nurse.

Date of Signature _____ Signature of Parent or Legal Guardian _____ Phone: Home _____ Work _____

Reviewed by School Staff _____ Date _____