

**Intermediate School District 917 Special Education Programs:
Authorization and Request for Administration of Medications**

Student: _____ **Birth Date :** _____ **School Year** _____

Drug Allergies: No Yes **If yes, list:** _____

Please include as needed non-prescription medications (i.e. Tylenol, Advil, etc.)

- For asthma inhaler medication, please complete an asthma authorization and plan (included)
- For seizure rescue medications, please complete annual history and action plan for student with seizure history (included)
- For an epi-pen rescue medication, please complete an anaphylaxis medication authorization and plan (included)

Health Condition/Diagnosis: _____

Medication: _____ **Time(s):** _____ **Duration:** _____

Dose: _____ **Route*:** _____ **Reason:** _____

*Route is the manner in which the medication is administered (by mouth, per gastrostomy tube, nebulization, etc.)

Parent/Guardian Authorization

- I understand that I am to furnish all necessary medications.
- I understand that parent/guardian authorization is required for any prescriptive or non-prescriptive medication to be given at school.
- Prescriptive medications must have a physician or licensed provider authorization.
- Non-prescriptive medications may need a physician or licensed provider authorization at the discretion of the licensed school nurse.
- Students are prohibited from using a medication, including an inhaler, that is not authorized for their personal use.
- I will notify the school immediately if my child's health status changes, or there is a change or cancellation of the medications.
- I understand all medications must be provided with an accurately labeled prescription container (please ask your pharmacist for the medication to be divided into two bottles completely labeled: 1 for school, 1 for home). Non-prescriptive medications provided by parent must be in an original container with label and directions.
- I have read the "Parent/Guardian Authorization" (above) and agree to the instructions it provides.

Parent/Guardian Signature: _____ **Date:** _____

- I authorize the school nurse to contact the licensed provider as needed concerning the child's health needs, the actions of the medication (s), and clarify administration instructions.

Provider /Clinic: _____ **Phone #** _____

PHYSICIAN AUTHORIZATION REQUIRED FOR ALL PRESCRIPTION MEDICATIONS

Licensed School Nurse *may* require physician authorization for any medication(s) given at school.

Physician Authorization

- I have reviewed the medication plan and approve of it as written.
- I have reviewed the medication plan and approve of it with the attached amendments.
- List special instructions and/or possible side effects: _____
- I do not approve of the medication plan. A substitute plan is attached.

Physician Signature: _____ **Date:** _____

The above medications may not necessarily be administered by a school nurse. The medications may be administered by school personnel trained and supervised by a licensed school nurse.

For office use only:

Name of Staff Routing: _____ **Date:** _____ **Please check off what was routed.**

___ Student File ___ IEP Manager ___ 917 LSN ___ Building Nurse