EverGreen Elementary Medication Authorization

Student Name ______________________ Date of Birth

Student's Home Address ______ Apt# ______ Zip Code ______ Telephone #

PARENT/GUARDIAN AUTHORIZATION

Name of Medication (please print) ______ Dose ______ Time(s) to Administer

Asthma Rescue Inhalers: My child may carry & self administer the asthma rescue inhaler requested above	___ YES ___ NO
Epinephrine Auto-Injection: My child may carry & self administer the auto-injectable epinephrine requested above	___ YES ___ NO

I, the parent/guardian of the above names student, request the prescription medication listed above be given at school. I will notify the school in writing if there is a change or cancellation of the medication. I understand that students may not carry or self-administer narcotics or Level II Controlled Substances. EverGreen has my permission to contact the prescriber about this medication. I authorize the release of information about the administration of this medication to appropriate school personnel and classroom teachers who have a need to know.

Parent/Guardian Signature: ______ **Date:**

PRESCRIBER AUTHORIZATION

Name of Medication (please print) ______ Dose ______ Time(s) to Administer

Administer for: ___________ Full School Year: _____ Partial Year: Begin _________ End ________

Reason medication is given at school: ______________________

Side effects or contraindications: ______________________

If PRN, indications for use: ______________________

If PRN, actions after administration (if needed): ______________________

SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION: Complete if applicable

Asthma Rescue Inhalers: It is my professional opinion that the student **MAY** carry and self-administer the asthma rescue inhaler prescribed above	___ YES ___ NO
Epinephrine Auto-Injection: It is my professional opinion that the student **MAY** carry and self-administer the auto-injectable epinephrine prescribed above.	___ YES ___ NO
OTHER MEDICATIONS: It is my professional opinion that the student **MAY** carry and self-administer the medication prescribed above.	___ YES ___ NO

DISCONTINUING A PREVIOUSLY PRESCRIBED MEDICATION: Complete if applicable

Please discontinue the administration of the medication listed below:

Name of Discontinued Medication (Please Print) ______ Dose ______ Time(s) to Adminster

I authorize the administration of this medication to the student named above. I agree to be contacted by EverGreen Elementary as needed regarding this medication.

Signature of Prescriber ______ Prescriber's Name (Please Print) ______ Date