School Medication Authorization Form
Physician Authorization
Pinckneyville Community High School District #101

__________________________ __________ ____________ __________
Student's Name Birth Date School/District Date

Please complete the designated areas marked below and return to the school nurse. This information is confidential between the physician, parent, teacher, and school nurse. Thank you for your cooperation.

______**Physician Authorization for Medication at School:**

I am requesting that the above named student take the following medication during school hours.

____ ____________________________
Name of Medication/Health Care treatment Dosage/Route

____
Frequency/Time to be administered

____
Diagnosis requiring Medication

____
Side effects/Reactions to these medications to which the nurse and/or teacher should be alert.

______**Asthma Plan:** Personal Best Peak Flow number**:**___________

If this student does have problem with "endurance" sports, please permit him/her to take the following medication:____ *before* participating to *prevent* symptoms.

In case of breathing difficulty, acute asthma attack, have the child take prescribed medication:

____

Other instructions:____

* If the treatment is ineffective or symptoms are severe, transport to the ER immediately.

______**Authorization for Self-administered medication (asthma inhalers, Epi-pen, glucose)**

___ I have instructed ___________________________in the proper way to use his/her medications. It is my professional opinion that he /she should be allowed to carry and use that medication by him/ herself.

___ It is my professional opinion that ______________________should not carry self-administered medication by him/herself.

______**List other medications the child is receiving** ____

____

________________ ________________
Start Date/Stop Date Re-evaluation Date

____ _______________________________
Physician Signature Date signed

____ _______________________________
Physician's Emergency phone number Physician's address

5/2017