LaHarpe School District # 347 Student Medication Authorization

(Required when a student needs to take prescription and/or non-prescription medication at school)

Student Name _____ DOB _____ Date _____

School medications and health care services are administered following these guidelines:

- ☐ Physician/prescriber signed and dated authorization to administer the medication
- ☐ Parent/guardian signed and dated authorization to administer the medication
- ☐ The medication must be in the original labeled container as dispensed or the manufacturer's labeled container
- ☐ The medication label must contain the student's name, name of the medication and directions for use and date
- ☐ Annual renewal of authorization and immediate notification of changes is required.

Physician Authorization:

_____ _____ _____
Medication/ Treatment Dosage Time to be Administered

_____ _____
Intended Effect of Medication/Treatment Side Effects (if any)

_____
Other Medication the Student is Taking

May the student self-administer the medication under the supervision of a school designee? _____ Yes _____ No

Administration Instructions:

_____
_____

Date to Discontinue, Reevaluate or Follow Up:

_____

_____ _____
Physician's Signature Date Signed

_____ _____
Physician's Emergency Phone Number Physician's Address

✂ Parent Signature _____ Date _____