School medication authorization
Student medication authorization form

Utah Department of Health and Human Services in accordance with UCA 53G-9-501

Date: School:	Student picture			
Student information		Date of birth:		
Student name:	School:	Grade		
Parent name:	Phone:	Email:		
Prescriber name:	Phone:	Fax:		
School nurse name:	School phone:	Fax:		

Parents must complete this page, sign it, get a signature from their child's healthcare provider, and return the signed form to the school.

If a request is being made for school staff to administer asthma medication, epinephrine auto-injector, diabetes medication, or seizure rescue medication, an additional form(s) specific to these medications is also required. Those forms must also be signed by the parent and physician and kept on file at the school. These supplemental forms are also required for students to carry and self-administer asthma medication, epinephrine auto-injectors, and diabetes medications. Seizure rescue medication cannot be carried by a student.

As parent/guardian I request the medication(s) listed below be given to my student during regular school hours.

☐ I understand medication will be administered by trained school employee volunteers.
☐ I understand a new medication authorization form will be required each school year, and whenever there is a dosage change.
☐ I understand I am responsible for maintaining necessary supplies, medications, and equipment.
☐ I understand prescription medication must be transported to and from school by an adult*.
☐ I understand all medication, both prescription and over-the-counter, must be in the manufacturer or current pharmacy container and label, with my student's name, medication name, administration time, dosage, and healthcare provider's name.
☐ I understand the information contained in this order will be shared with school staff on a need-to-know basis.
☐ I understand it is my responsibility to notify the school nurse of any change in my student's health status or medication order.
☐ I understand that expired medication cannot be administered to my student.

I give permission for my student's healthcare provider to share information with the school nurse for the completion of this medication order.

Parent name:	Phone:
Parent signature:	Date:

*Students may carry some medication in certain circumstances. This applies to asthma medication, epinephrine auto-injectors, and diabetes medications, and **only** after another form specific to that medication is completed and turned into the school. **District and school medication policies may allow students to carry and administer other medications**.

Student name:	Student date of birth:

Healthcare provider: this section of the form must be filled out and signed by the student's healthcare provider. Only an MD/DO, nurse practitioner, certified physician's assistant, or a provider with prescriptive practice can fill out and sign this section of the form.

Name of medication	Diagnosis/ reason for administration	Dosage	Route	Time	Side effects of the medication

This student is under my care, and I have prescribed this medication(s) for the named student. It is medically necessary for the medication to be administered while the student is at school.

☐ **It is** medically appropriate for the student to self-carry* this medication, **when able and appropriate,** and always have possession of this medication and supplies (see statement above under medication Information). This student has been trained to self-administer the medication and can do this safely.

☐ **It is not** medically appropriate for the student to self-carry and self-administer this medication. Only the appropriate/designated school personnel can maintain this student's medication for use at school if needed.

Other (specify):

Name	Signature	Date
Prescriber:		
School nurse:		
Principal:		
Other:		

To be completed by school nurse

Plan of care/nursing interventions:	Plan of care/nursing interventions:
☐ Get parent and licensed prescriber authorization for medications to be given at school. ☐ Administer medication(s) as prescribed. ☐ Train staff who are responsible for the healthcare of the student during the school day on how to properly administer the medication. ☐ Assess knowledge and learning needs of staff related to management of chronic conditions and medication administration for staff administering medications. Remediate when necessary. ☐ Other (specify):	☐ Get parent and licensed prescriber authorization for medications to be given at school. ☐ Administer medication(s) as prescribed. ☐ Train staff who are responsible for the healthcare of the student during the school day on how to properly administer the medication. ☐ Assess knowledge and learning needs of staff related to management of chronic conditions and medication administration for staff administering medications. Remediate when necessary. ☐ Other (specify):

☐ Signed by physician and parent	☐ Medication is appropriately labeled	☐ Medication log generated

Medication will be kept: ☐ In the office ☐ In the classroom ☐ Self-carry
☐ Other (specify):

School nurse signature:	Date: