School medication authorization Student medication authorization form Utah Department of Health and Human Services in accordance with UCA						Student picture	
53G-9-501 Date of birth:							
Student information	Calcala	Date of t					
Student name:	School:		Grade				
Parent name: Prescriber name:	Phone: Phone:		Email:				
School nurse name:				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. Fax:							
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 autoinjectors, 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 pro	ovider: this sectior	n of the fo	rm must be	e filled out	and signed by	the student's		
healthcare pro	ovider. Only an MD)/DO, nurs	se practitio	ner, certif	ied physician's a	assistant, or a		
provider with	prescriptive praction	ce can fill	out and sig	n this sec	tion of the form	າ.		
Name of	Diagnosis/	Dosage	Route	Time	Side effects of	f the medication		
medication	reason for							
	administration							
	nder my care, and I ha	•				it. It is medically		
necessary for the	medication to be adr	ministered v	while the stud	ent is at sch	nool.			
— 			, , , ,			• . • •		
2	appropriate for the stu		-		• •			
•		••			ler medication Info	ormation). This student		
has been trained	to self-administer the	e medication	h and can do t	this safely.				
	- II			-I IC I!		ing Onlytha		
	ally appropriate for the		-			-		
appropriate/desig	gnated school person	nel can mai	ntain this stu	dent's medi	cation for use at so	chool if needed.		
Other (specify):								
Name			Signature			Date		
			Signature			Date		
Name			Signature			Date		
Name Prescriber:			Signature			Date		
Name Prescriber: School nurse:			Signature			Date		
Name Prescriber: School nurse: Principal:			Signature			Date		
Name Prescriber: School nurse: Principal: Other:	ted by school nu	rse	Signature			Date		
Name Prescriber: School nurse: Principal: Other: To be comple	ted by school nu	rse	Signature		re/nursing interve			
Name Prescriber: School nurse: Principal: Other: To be comple Plan of care/nurs	-			Plan of ca	-			
Name Prescriber: School nurse: Principal: Other: To be comple Plan of care/nurs Get parent and medications to be	ing interventions: d licensed prescriber a e given at school.	authorizatio		Plan of ca □ Get pa for medic	rent and licensed p ations to be given	ntions: prescriber authorization at school.		
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□ Signed by physician and parent	Medication is appropr	ately labeled	□ Medication log generated
Medication will be kept:	ne office 🛛 In the class	room 🗆 Se	lf-carry
School nurse signature:		Date:	