VALLEY CHILDREN'S CLINIC, PLLC
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Authorization For Administration of Medication at School

Student's Name_____Birthdate_____
School_____Grade_____

Name of Medication	Dosage	Method Of Administration	Time of Day To Be Taken
_____	_____	_____	_____
_____	_____	_____	_____

Inhalers:_____Indicate if student must carry on his/her person Yes____ No____

Reason for medication to be given during school hours:_____

_____

Anticipated action:_____

Possible Side effects of medication:_____

Emergency procedure in case of serious side effects:_____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period commencing with the _____day of_____, _____(year) through the _____day of _____, _____(year) as there exists **a valid health reason which makes administration of the medication advisable during school hours** or during such time that the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel.

_____ _____
Date of Signature Licensed Health Care Provider's Signature

Printed Name of Physician_____

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This portion of the form is to be completed by the parent/guardian

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or doctors instructions for the period beginning the _____day of_____, _____(year) through the _____day of _____, _____(year) (not to exceed one school year). I also understand that the School Nurse may contact the prescriber regarding questions related to this medication. **Medication will be supplied to the school in the original container.**

Date of Signature_____Signature_____
Home phone #_____Cell #_____Work#_____