

ELKHORN PUBLIC SCHOOLS HEALTH SERVICES
VISITING NURSE SCHOOL HEALTH PROGRAM
MEDICATION AUTHORIZATION

Student _____ Grade _____ Age _____ School _____

PHYSICIAN DIRECTIONS

Medication to be given _____

Dosage _____ Route _____ Time _____

Starting date _____ Termination date _____

Purpose of medication _____

Possible side effects/observations to note _____

Physician requests comments from school? Yes _____ No _____

This medication may be safely given by an unlicensed individual who has demonstrated competency in medication provision.

Physician Signature _____ Phone _____ Date _____



I request the student above receive the medication as ordered by the physician while in school and school related activities. I understand it is my responsibility to furnish the medication in the original container or prescription bottle appropriately labeled by the pharmacy or physician stating name of medication, dosage and instructions. I accept the responsibility of monitoring the action and side effects of the medication and ask that I be notified if the following occurs:

Parent/Guardian Signature _____

Address _____

Phone _____ (home) _____ (work) _____ (other) _____

Complete this section in addition, ONLY if medication is PRN/as needed:

Medication should be provided when: _____

Notify if/additional instructions: _____

I find the following unlicensed individuals/s competent to provide the medication stated

Above: _____ on file at the central office _____

Parent Signature _____ Date _____

Complete this section in addition, ONLY if medication is to be given by route OTHER THAN oral, inhalation, topical or instillation:

Written procedure (may be attached)

I find the following unlicensed individual's competent to provide the previously stated medication: _____

Parent Signature _____ Date _____

Complete this section in addition ONLY if participation in monitoring is necessary:

I request that the following observations be made and reported to me in the time lines stated: _____

I find the following unlicensed individual/s competent to assist in monitoring the Previously stated medication: _____

Parent Signature _____ Date _____