

JORDAN SCHOOL DISTRICT NURSING SERVICES SCHOOL MEDICATION AUTHORIZATION FORM

School Year: _____

Student's Name: _____

Birth Date: _____

School: _____

Grade: _____

Teacher: _____

TO BE COMPLETED BY HEALTHCARE PROVIDER:

This order can only be signed by Physician (MD, DO), Dentist, Nurse Practitioner (NP, FNP, PNP, APRN/PP), or Certified Physician's Assistant. **Utah Law requires that medication administered during school hours must be medically necessary.**

ONLY ONE MEDICATION PER FORM

Diagnosis: _____

Medication: _____

Duration To Be Given: _____

Dosage: _____

Time: _____

Route: _____

Reportable Adverse Reactions/Side Effects: _____

Special Instructions: _____

MEDICATION SELF-ADMINISTRATION AUTHORIZATION

*According to Utah State Law Students are **only** allowed to carry and self-administer epinephrine auto injectors, asthma inhalers and insulin. The above-named student is under my care and has been trained in self-administration of the following medication, and is capable of carrying and self-administering the indicated medication:*

Auto-Injectable Epinephrine

Inhaler

Insulin

Name of Healthcare Provider: _____ Phone: _____

Healthcare Provider Signature: _____ Date: _____

PARENTAL RESPONSIBILITIES:

- Parent must furnish the school with a completed *School Medication Authorization Form* prior to any medications being administered by school personnel.
- The medication must be delivered to the school by the parent or designated adult in the original container, labeled with the child's name, medication, time, dosage, and healthcare provider's name.
- All medication must be delivered to the school by the parent or designated adult and picked up by the parent or designated adult within two (2) weeks of last dose given.
- If there is a change in the medication or medication dosage, a new *School Medication Authorization Form* must be completed before school personnel can administer the new medication or new medication dose.

I UNDERSTAND THAT BY SIGNING THIS FORM:

- I am giving permission to the school personnel to contact the healthcare provider regarding this medication.
- I am giving permission for this medication to be administered by someone other than a licensed nurse who has been appointed by the school administrator.
- (Except in the case of glucagon or auto-injectable epinephrine), school personnel CANNOT administer:
 - the 1st dose of a new medication, OR
 - the 1st dose of a *dosage change* of any medication.

Parent Signature: _____ Date: _____ Emergency Phone Number: _____

District Nurse Signature: _____