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 <u>must be medically necessary</u>.**

*** ONLY ONE MEDICATION PER FORM ***

Diagnosis: ________________________________

Medication: ________________________________ **Duration To Be Given:** ______________________

Dosage: ______________________ **Time:** _____________ **Route:** ______________________________

Reportable Adverse Reactions/Side Effects: ____

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Special Instructions: ____

<u>MEDICATION SELF-ADMINISTRATION AUTHORIZATION</u>

*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* <u>prior</u> 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.
- <u>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.</u>

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.
- <u>*(Except in the case of glucagon or auto-injectable epinephrine)*</u>, 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: ___________________________

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