STUDENTS 09.2241 AP.2

## PHYSICIAN ORDER AND PARENT/GUARDIAN AUTHORIZATION FOR SELF MEDICATION ADMINISTRATION

(Please complete one form for each medication.)

Student's Name:	DOB:
Allergies:	
	Dosage:
Reason for medication or diagnosis:	
School:	School Year:
authorization form. Also, a Physician's Order (see Please be sure to complete ALL of the informat	ation at school, the Parent/Guardian shall provide this signe box below) is required for students to self-administer medication ion on this authorization form before returning it to school. This to be renewed at the beginning of each new school year.
own medication. For elementary age childre	school students are allowed to carry and self-administer the n, arrangements can be made to keep inhalers or emergence eacher will provide monitoring for the child's safety.
PH	YSICIAN'S ORDER
<ol> <li>I have examined this student for (diagnosis): and have determined that he/she requires me</li> </ol>	edication during school hours.
2. Name of Medication	3. Dosage & Route:
<ol> <li>I believe this student is able to carry and adm appropriate way. Please check:YES</li> </ol>	ninister his or her own medication at the appropriate time and in the NO
Physician's Signature:	// Date://
Printed Name:	Phone:
PARENT/0	GUARDIAN STATEMENT
Education Medication Policies & Procedures to release and hold the school staff free and any injury or complication that may result from	give conser- gove medication(s). I understand the Fayette County Board of s (09.2241) are readily available for me to read. I hereby agreed tharmless for any claims, demands, or suits for damages from som such treatment. I have read this consent and understand a nowledge of its significance. I understand that self-administered the School Nurse or school staff.
	nitor student periodically during the school year.
* Parent / Student are respon	nsible to have the medication available at school.
X(Parent/Guardian Signatur	re)/
Home Phone:	Nork:Cell:
Reviewed by:	RN Date