ACADEMIA CESAR CHAVEZ

MEDICAL AUTHORIZATION FORM SCHOOL YEAR:

Parent/Guardian AND a licensed healthcare professional must provide written permission for school personnel to administer medication(s) every school year.

Student:_____ **DOB:**_____**Grade:**_____

PHYSICIAN/LICENSED PROVIDER - PLEASE COMPLETE

MEDICATIONS REQUIRED DURING SCHOOL HOURS

All Authorizations expire at the end of the school year or following extended year summer session

Medication/Treatment	Diagnosis	Dose	Time	Route	Possible Side Effects
1.					
2.					
3.					

Inhaler - Please include Asthma Action Plan:

☐ Student may carry/self administer his/her inhaler according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.

☐ It is my professional opinion that this student **should not carry** his/her inhaled medication.

Epinephrine auto-injector - please included Anaphylaxis Action Plan:

☐ Student may carry/self administer epinephrine auto-injector (Epi-Pen) according to the licensed prescribers instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.

☐ It is my professional opinion that this student **should not carry** his/her Epi-pen/auto-injector.

Other:

☐ Student may carry/self administer _____(please identify).

_____ _____ _____

Signature of Licensed Health Care Provider **Printed name** of Licensed Healthcare Provider Date

_____ _____ _____

Clinic Name/Address Clinic Phone # Clinic Fax #

PARENT/GUARDIAN MEDICATION AUTHORIZATION

1. I request the medication listed be given during the school hours as ordered by this student's licensed healthcare provider. Only daily medications and those for life threatening/emergency conditions will be sent on field trips.
2. I will provide the school with physician/licensed prescriber authorization for any change in medication(s) and/or treatment(s). (Example: dosage change, time change, discontinued, etc.)
3. I give permission to designated school staff to administer the above medication(s) and/or perform treatments. I release the school personnel from any liability in the administration of this medication or treatment.
4. **I understand that school health staff cannot administer the medication(s)/treatment(s)/procedure(s) indicated on this form without authorization from both my student's physician/licensed prescriber and guardian/parent.**
5. I give permission for health office staff to consult with this student's licensed healthcare provider regarding questions about the above medical condition(s) and medication/procedure being used to treat the condition.
6. I give permission for the health office staff to communicate as needed with school staff about my student's health condition(s) and the action of the medication and/or treatment.

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian name (please print)_____ Tel #_____