HIGHLAND SCHOOL DISTRICT 203 MEDICAL AUTHORIZATION FOR MEDICATION MANAGEMENT AT SCHOOL

SCHOOL:		YEAR:			
STUDENT:					
DOB:A					
PARENT/GUARDIAN (PRIN	NT):				
	PARENT/	GUARDIAN SECT	ION		
SECCION DE PADRE/GUARDIAN					
I request the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare instructions. I give permission for the following medication information to be shared with school staff on a "need to know" basis.					
Yo pido que la enfermera o personal designado, le administer el medicamento recetada de acuerdo con las instrucolones del medico. Doy permiso que la siguiente informacion sea compartida con el personal escolar que necisita estar informado.					
Parent/Guardian Signature	e Date	Home Phone	/ Em	nergency phone	
Firma de Padre/Guardian	Fecha			efono de Emergnecia	
	HEALTHCA	RE PROVIDER SE	CTION		
Primary Dx for Rx:					
Medication (name, strengt	h, and form)	Dose	Route	Time to be Given	
If PRN, specify length of ti	me between dose	es:			
Other directions for use: _					
Possible side effects:					
Emergency action:				or □ Call 911	
Duration of order (Must ch	oose one)				
☐ Medication order is only Year:		school year (which	may include su	ımmer school)	
☐ Medication order valid o	only for specified	date range:/	/ to)/	
HCP signature:			Date:		
HCP Printed name:		P	Phone:		

ONE FORM PER MEDICATION

If med is not PRN, a specific time of day must be indicated, it cannot read: "AM/PM, morning/afternoon hours, lunchtime," etc. Lunch hours vary by building, grade, and sometimes day of the week, but always occur between 1100-1400. If medication may or may not be crushed or opened (i.e., a capsule) &/or taken with applesauce, please indicate so on the **Other directions for use** line. Thank-you. For questions, please contact Highland District Nurse at (509) 678-8904. ver 5/2023