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 (53a-11-501) 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 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 an adult and picked up by an 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:
  o the 1st dose of a new medication, OR
  o the 1st dose of a dosage change of any medication.

Parent Signature: ____________________________ Date: ____________________________ Emergency Phone Number: ____________________________

District Nurses Signature: ____________________________

White – School Copy Yellow – District Nurse Copy Pink – Parent Copy

Rev. 10/06 A-0298 Revised 9/2008