

MARISSA COMMUNITY UNIT SCHOOL DISTRICT #40
Official Board Policy

October 2010

7:270-E
Page 1 of 2

Students

Exhibit - School Medication Authorization Form

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

School: _____ Grade: _____ Teacher: _____

To be completed by the student's physician, physician assistant, or advanced practice RN (Note: for asthma inhalers only, use the "Asthma Inhalers" section below):

Physician's Printed Name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

Medication name: _____

Purpose: _____

Dosage: _____ Frequency: _____

Time medication is to be administered or under what circumstances: _____

Prescription date: _____ Order date: _____ Discontinuation date: _____

Diagnosis requiring medication: _____

Is it necessary for this medication to be administered during the school day? Yes No

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Other medications student is receiving: _____

Physician's signature

Date

Asthma Inhalers

Parent(s)/Guardian(s) please attach prescription label here:

MARISSA COMMUNITY UNIT SCHOOL DISTRICT #40
Official Board Policy

October 2010

7:270-E
Page 1 of 2

Students

Exhibit - School Medication Authorization Form

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

School: _____ Grade: _____ Teacher: _____

To be completed by the student's physician, physician assistant, or advanced practice RN (Note: for asthma inhalers only, use the "Asthma Inhalers" section below):

Physician's Printed Name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

Medication name: _____

Purpose: _____

Dosage: _____ Frequency: _____

Time medication is to be administered or under what circumstances: _____

Prescription date: _____ Order date: _____ Discontinuation date: _____

Diagnosis requiring medication: _____

Is it necessary for this medication to be administered during the school day? Yes No

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Other medications student is receiving: _____

Physician's signature

Date

Asthma Inhalers

Parent(s)/Guardian(s) please attach prescription label here: