SCHOOL TOWN OF HIGHLAND
HEALTH SERVICES

AUTHORIZATION TO ADMINISTER MEDICATION DURING SCHOOL HOURS
(To be placed in student's file after signing)

PHYSICIAN'S STATEMENT (required for **prescription** medications only)

I have prescribed the medication indicated below for:

_____, and do hereby authorize the nurse,
Student's Name

principal, or their designee, of the school to administer the medication as indicated:

DIAGNOSIS: _____

MEDICATION: _____

DOSAGE and TIME to be given: _____

Student may hand carry AND self-administer this medication: Yes_____ No_____
(must be a life-threatening condition, such as asthma)

Date: _____ _____
Physician's Signature

PARENTAL AUTHORIZATION (required for ALL medications)

I wish _____ to receive:
Student's Name

_____ at _____
name of medication and dosage time to be given

I agree that this student may hand carry AND self-administer this medication:
(must be a life-threatening condition, such as asthma) YES_____ NO_____

Date: _____ _____
Parent Signature

PLEASE NOTE: The physician's statement and the parental authorization are valid only for the current school year. Unless the authorization and statement are renewed, the medication cannot be given to the student. Refer to the Parent Handbook for the complete policy.
6/09 da