CUMBERLAND SCHOOL DEPARTMENT

MEDICATION AUTHORIZATION FORM

I give permission for ____ at ____________________
(Name of Student) (Name of School)

DOB: ___/___/___ Grade: ___ to receive ______________________________ as ordered below.
(Name of Medication)

Dosage to be administered: ____________________________ Route: _______________

Time to be administered: ________ Reason for Medication: _______________________

Duration: From: ___________________________ to: ___________________________
(Start Date) (End Date)

Possible Side Effects: ____

Does the school nurse/teacher have permission to release this information to school personnel who may have a need to know (i.e.: teacher, principal)? **YES** **NO**

Physician's Signature: ____ Date: _____________

Physician's Phone: ______________________ Physician's Fax: _________________________

Parent's Signature: ____ Date: _____________

PERMISSION TO SELF-CARRY/SELF-ADMINISTER MEDICATION:

Please circle medication INHALER EPI-PEN INSULIN OTHER: ____________________
(specify)

- I have instructed __________________________ in the proper use and administration of his/her medication. It is my professional opinion that he/she should be allowed to carry and use this medication by himself/herself.
- It is my professional opinion that ____________________________ should not self-carry or self-administer his/her medication.

Physician's Signature: ____ Date: _____________

Parent's Signature: ____ Date: ____________