

School Year  
20\_\_ - 20\_\_



School Fax  
316-973-\_\_\_\_\_

**AUTHORIZATION FOR MEDICATION/PROCEDURE  
TO BE ADMINISTERED AT SCHOOL & FIELD TRIPS**

**Part A - Parent to Complete**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school or on a field trip as indicated by my child's health care provider as described in Part B listed below.

I understand I must provide all

1. medication in its original labeled container and/or
2. necessary supplies

I also give permission for communication between the school health professional and the medical prescriber and dispensing pharmacy related to the specific medication/treatment in question, including communication concerning:

1. the prescription or treatment itself – i.e., questions regarding dosage, method of administration, and potential drug interactions.
2. implementation of the treatment in school – i.e., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule.
3. student outcomes from the treatment – i.e., questions regarding observed side effects, possible negative reactions, observations of behavior changes in the classroom.
4. other pertinent issues related to the student's diagnosis, condition, or treatment.

_____ Parent /Legal Guardian Signature	_____ Printed Name of Parent /Legal Guardian	_____ Today's Date
_____ Home Phone	_____ Cell Phone	_____ Work Phone
_____ Parent Designee Name	_____ Parent Designee Cell Phone	_____ Parent Designee Work Phone

**Part B - Health Care Provider to Complete**

**MEDICATION AND/OR TREATMENT ORDERS:** (please specify)

Medication / Treatment	Dosage / Route	Time / Frequency	Diagnosis(es) / Indication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_

_____ Signature of Physician/APRN/PA	_____ Printed Name of Physician/APRN/PA	_____ Name of the Supervising Physician for APRN/PA
_____ Health Care Provider Phone Number	_____ Health Care Provider FAX Number	_____ Today's Date

***This student has demonstrated the skill level necessary to self-administer such medication/treatment.***

**Yes** \_\_\_\_\_  
Signature of Physician/APRN/PA Medication(s)/Treatment(s) that can be self-administered

**DEPARTMENT OF HEALTH SERVICES**  
**GUIDELINES FOR MEDICATION &**  
**PROCEDURES - Prescribed Special Health Care Services (PSHCS)**

Refer to BOE Policy 5316 & 5317 ~Revised September 22, 2015

**Medication & Procedure/PSHCS requests must be renewed each school year**

**Procedures/PSHCS** are services

- ❖ prescribed by a health care provider that require specialized training to implement.
- ❖ that are necessary to enable the student to attend school and/or programs occurring before/after school and hosted or controlled by the school. Examples of Procedures/PSHCS include injections such as insulin and emergency auto injectors.

**The Licensed Registered Professional School Nurse**

***Regarding non-prescription and prescription medication***

1. must review all medication requests prior to initiating their administration.
2. may designate and train non-nurse school employee(s) to administer medication.
  - a. *If at all possible, medications should be taken prior to coming to school or after leaving school under parental supervision.*

***Regarding Procedures/PSHCS***

1. is responsible to review and process the request for the Procedure/PSHCS.
2. is involved in the planning and provision of the services.
  - a. *The result of this planning will result in the student's own **Emergency Medical Plan - EMP.***
3. may designate and train non-nurse school employee(s) to perform Procedure/PSHCS.

**The Parent/Legal Guardian –**

1. must provide a new **Authorization for Medication/Procedure at School** each school year.
  - a. *The signature of the parent/legal guardian and completion of the **Authorization for Medication/Procedure at School** authorizes an exchange of information with the school and health care provider/agency.*

***Regarding non- prescription and prescription medication***

1. must notify the school immediately regarding changes. Any changes in dosage or schedule require a
  - a. *new written request from the health care provider*
  - b. *correctly labeled medication container*
2. will contact the nurse prior to the end of the year to discuss arrangements for transfer of medication.

***Regarding Procedure/PSHCS***

1. must notify the school immediately regarding changes.
  - a. *Changes require a new written request from the health care provider and approval of the nurse.*
2. is responsible for providing, maintaining, servicing and replacing necessary equipment and supplies– i.e., syringes, tubing, glucose tabs, etc.
  - a. *Equipment must be correctly labeled with directions for use.*
3. will contact the nurse prior to the end of the year to discuss arrangements for transfer of equipment.