Carman-Ainsworth Community Schools
Authorization to Administer Medication at School
Required for all Prescription and Non-Prescription Medication

School: ❍**High School** 591-3240/591-3215 (Fax)
❍**Middle School** 591-3500/591-3594 (Fax)
❍**Atlantis Alt.** 591-3276/591-3265 (Fax)
❍**C-A/Baker Career** 766-2236/766-2248 (Fax)
❍**Dillon Elem** 591-3590/591-3835 (Fax)
❍**Dye Elem** 591-3229/591-3310 (Fax)
❍**Randels Elem** 591-3250/591-3225 (Fax)
❍**Rankin Elem** 591-4605/591-8440 (Fax)

Student's Name____ **DOB** _____/_____/________

Teacher/First Hour____ **Grade**___________________

To be completed by Physician

Name of Medication:____

Reason for Medication: (Optional)____

Form of Medication: ❍Tablet/Capsule ❍Liquid ❍Inhaler ❍Injection ❍Nebulizer ❍Other ______________

Instructions: (frequency/time and **dose**)____

Possible side effects: ❍None Anticipated ❍Yes, explain ______________________________________

Special storage: ❍None ❍Refrigerate ❍Other_______________

Start Date: ❍Once both medicine and completed form are received ❍Other date________________

Stop date: ❍End of school year ❍Other date_______________

Self-Administration

This student is capable and responsible for carrying and self-administration of this medication:

❍Yes ❍No ❍Yes, with supervision (may self-administer, medication to remain with staff)

Physician Signature____ **Date**____________________

Physician Name____ **Phone**___________________

To be completed by Parent/Guardian

I request that (student's name)___________________________________ receive the above medication according to school policy. I give permission for exchange of verbal and written communication between the physician and the school nurse and/or designated school staff regarding my child's medication. I request that my child be assisted in taking the medication described above or be permitted to carry and self-administer as authorized by the physician above.

Parent/Guardian Signature____ Date__________________

Parent/Guardian Name____ Phone_________________

*One Authorization to Administer Medication form must be filled out for **EACH** medication the student may take at school.
*Additional forms available at any school office or from the district nurse.

For Office Use Only

❍Parent signed ❍Dr. signed ❍Med received **and/or** ❍Student carries(labeled)

Updated/Reviewed April 2017