CANYONS SCHOOL DISTRICT NURSING SERVICES
SCHOOL MEDICATION AUTHORIZATION FORM

School Year: _____

Student's Name: _____ **Birth Date:** _____

School: _____ **Grade:** _____ **Teacher:** _____

TO BE COMPLETED BY HEALTHCARE PROVIDER:

This order can only be signed by Physician (MD, DO), Dentist, Nurse Practitioner (NP, FNP, PNP, APRN/PP), or Certified Physician's Assistant. **Utah Law (53a-11-501) requires that medication administered during school hours must be medically necessary.**

*** **ONLY ONE MEDICATION PER FORM** ***

Diagnosis: _____

Medication: _____ **Duration To Be Given:** _____

Dosage: _____ **Time:** _____ **Route:** _____

Reportable Adverse Reactions/Side Effects: _____

Special Instructions: _____

MEDICATION SELF-ADMINISTRATION AUTHORIZATION

According to Utah State Law Students are only allowed to carry and self-administer epinephrine auto injectors, asthma inhalers and insulin. The above named student is under my care and has been trained in self-administration of the following medication, and is capable of carrying and self-administering the indicated medication:

☐ Auto-Injectable Epinephrine ☐ Inhaler ☐ Insulin

Name of Healthcare Provider: _____ **Phone:** _____

Healthcare Provider Signature: _____ **Date:** _____

PARENTAL RESPONSIBILITIES:

- Parent must furnish the school with a completed *School Medication Authorization Form* prior to any medications being administered by school personnel.
- The medication must be delivered to the school by the parent in the original container, labeled with the child's name, medication, time, dosage, and healthcare provider's name.
- All medication must be delivered to the school by an adult and picked up by an adult within two (2) weeks of last dose given.
- If there is a change in the medication or medication dosage, a new *School Medication Authorization Form* must be completed before school personnel can administer the new medication or new medication dose.

I UNDERSTAND THAT BY SIGNING THIS FORM:

- I am giving permission to the school personnel to contact the healthcare provider regarding this medication.
- I am giving permission for this medication to be administered by someone other than a licensed nurse who has been appointed by the school administrator.
- *(Except in the case of glucagon or auto-injectable epinephrine),* school personnel CANNOT administer:
  - the 1st dose of a new medication, OR
  - the 1st dose of a *dosage change* of any medication.

Parent Signature: _____ **Date:** _____ **Emergency Phone Number:** _____

School Nurse Signature: _____