Cascade
Union Elementary School District
Inspire - Believe - Achieve

SCHOOL MEDICATION AUTHORIZATION FORM

School of Enrollment:

- ☐ Anderson Middle School – Fax: 378-7061
- ☐ Anderson Heights – Fax: 378-7051
- ☐ Meadow Lane – Fax: 378-7031
- ☐ Community Day School – Fax: 378-7051

PHYSICIAN'S ORDER (To be completed by physician only)

Name of child:_____ DOB_____

Name of medication/strength:_____

Dosage:_____ How often?_____

Time to be given at school:_____ Dose form:_____

Reason for medication:_____

Possible side effects:_____

Length of time medication will be necessary:_____

☐ Student has been instructed by physician in the use of inhaler and may carry medication with them.

☐ Student has been instructed by physician in the use of the EPI-PEN and may carry medication with them.

Comments:_____

_____

The pupil for whom this medication is prescribed is under my care.

_____ _____

Print Name of Licensed Physician | Signature of Licensed Physician

_____ _____

Address of Physician | Phone | Date

TO BE COMPLETED BY PARENT:

I request that my child, _____, be assisted in taking the above prescribed medication at school by authorized persons. I will comply with the school's policies and procedures. I also authorize the school nurse to communicate with the Authorized Health Care Provider when necessary. I understand that I will be provided a copy of my child's completed Individual School Healthcare Plan (ISHP).

_____ _____

Parent Signature | Phone | Date

_____ _____

Address | Emergency Phone

Updated:
9/12/2014