School Medication Authorization Form

Forma de Autorización para el Medicamento Escolar

To be completed by the child's parent(s)/guardian(s) and kept in the school health office:
Los padres/guardián del niño(a) deben llenar esta sección y será guardada en la oficina de salud de la escuela:

Student's Name: *Nombre del estudiante:*		Birth Date: *Fecha de nacimiento*:
Address: *Dirección:*		
Home Phone: *Número de teléfono*:	Emergency Phone: *Número de teléfono en caso de una emergencia*:	
School: *Escuela:*	Grade: *Grado:*	Teacher: *Maestro/a:*

To be completed by the student's physician:
El médico del estudiante debe llenar la siguiente sección:

Physician's Printed Name:		
Office Address:		
Office Phone:	Emergency Phone:	
Medication:		
Dosage	Frequency:	
Time medication is to be administered or under what circumstances:		
Prescription date:	Order date:	Discontinuation date:
Diagnosis requiring medication:		
Intended effect of this medication:		
Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition?	☐ Yes ☐ No	
Expected side effects, if any:		
Time interval for re-evaluation:		
Other medications student is receiving:		

I acknowledge that it may be necessary for the administration of medication to be performed by an individual other than a school nurse, and specifically consent to such practices.

Physician's signature Date:

By signing below, I agree:

That I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices.

Firmando abajo, estoy de acuerdo:

Que yo soy la persona principalmente responsable de administrar la medicina a mi niño/a. Sin embargo, en caso de que yo no pueda hacerlo o en caso de una emergencia médica, por este medio autorizo al Distrito Escolar y sus empleados y agentes, en mi nombre y lugar, administrar o intentar administrar a mi niño/a (o permitir a mi niño/a aut- administrar, mientras bajo la supervisión de los empleados y agentes del Distrito Escolar), medicina legítimamente prescrita en la manera descrita arriba. ***Reconozco que puede ser necesario administrar la medicina a mi niño/a por un individuo aparte de la enfermera escolar, y expresamente consiento a tales prácticas.***

Parent/Guardian Printed Name
Nombre del Padre/Madre/Guardián escrito en letra de molde

Parent/Guardian Signature
Firma del Padre/Madre/Guardián

Date
Fecha