

# THE RANCHES ACADEMY SCHOOL MEDICATION AUTHORIZATION FORM

School Year \_\_\_\_\_

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

<p><b>TO BE COMPLETED BY HEALTHCARE PROVIDER:</b> This order can only be signed by Physician (MD, DO), Dentist, Nurse Practitioner (NP, FNP, PNP, APRN/PP), or Certified Physician's Assistant. <b>Utah Law (53a-11-601) requires that medication administered during school hours must be medically necessary. This applies to non-prescription and prescription medications.</b> <b>ONLY ONE MEDICATION PER FORM</b></p> <p>Diagnosis _____</p> <p>Medication _____ Duration to be given _____</p> <p>Dosage _____ Time _____ Route _____</p> <p>Reportable adverse reactions/side effects _____</p> <p>Special instructions _____</p> <p><b>Medication Self-Administration Authorization:</b> [ ] Yes [ ] No The above named student is under my care. I feel it is medically appropriate and the student is trained and capable to <u>carry and self-administer</u> the following indicated medications at all times:</p> <p>[ ] Inhaler                      [ ] Insulin                      [ ] Epi-Pen</p> <p>Name of healthcare provider _____ Phone _____</p> <p>Healthcare provider signature _____ Date _____</p>
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**PARENTAL RESPONSIBILITES:**

- 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 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 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.

***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.*

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Phone Number \_\_\_\_\_ Emergency Phone Number \_\_\_\_\_