SCHOOL MEDICATION AUTHORIZATION
Individualized Student Medication Plan

Utah Department of Health & Human Services In Accordance with UCA 53G-9-501

Date:

School:

STUDENT INFORMATION		**Grade:**
Student:	School:	DOB:
Parent:	Phone:	Email:
Prescriber Name:	Phone:	Fax:
School Nurse:	School Phone:	Fax:

Parent: complete the above section, read and sign below, obtain signature from Health Care Provider and return to school nurse.

As parent/guardian I request the medication(s) listed below be given to my student during regular school hours.

☐ I understand medication will be administered by trained school employee volunteers.
☐ I understand a new medication authorization form will be required each school year, and whenever there is a dosage change.
☐ I understand parent or guardian is responsible for maintaining necessary supplies, medications, and equipment.
☐ I understand prescription medication must be transported to and from school by an adult*****.
☐ I understand all medication, both prescription and over-the-counter, must be in the current original pharmacy container and label, with the child's name, medication name, administration time, dosage, and health care provider's name.
☐ I understand over-the-counter medication must be in the original manufacture container.
☐ I understand the information contained in this order will be shared with school staff on a need-to-know basis.
☐ I understand it is my responsibility to notify the school nurse of any change in my student's health status, care or medication order.
☐ I understand that expired medication cannot be accepted or administered to my student.

I give permission for my child's healthcare provider to share information with the school nurse for the completion of this order.
Parent Signature:_____ Date:_____

MEDICATION INFORMATION

If a request is being made for school staff to administer asthma medication, epinephrine auto-injector, diabetes medication, or seizure rescue medication, an additional specific form(s) will be required, and must be signed by the parent and physician, and kept on file at the school. These supplemental forms will also be required for students who carry and self-administer asthma medication, epinephrine auto-injectors, and diabetes medications. Seizure rescue medication cannot be carried by a student.

Name of Medication	Diagnosis/ Reason for administration	Dosage	Route	Time	Side Effects	Expected Outcomes

Additional Instructions to the school:

Medication will be kept: ☐ In the office ☐ In the classroom ☐ Other:

Student Name:	**Student DOB:**

PRESCRIBER SIGNATURE
This form must be signed by prescriber (i.e. ongoing caregiver) to be valid, and can only be signed by an MD/DO; Nurse Practitioner, Certified Physician's Assistant or a provider with prescriptive practice.

The above-named student is under my care and I have prescribed this/these medication(s) for the named student. It is medically necessary for medication administration while student is under the control of the school.

☐ It is medically appropriate for the student to self-carry* this medication, when able and appropriate, and be in possession of this medication and supplies at all times (see statement above under Medication Information). This student has been trained to self-administer the medication and is capable of doing this safely.

☐ It is not medically appropriate to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain this student's medication for use if needed.

Name	Signature	Date
Prescriber:		
School Nurse:		
Principal:		
Other:		

To be completed by School Nurse

Plan of Care/Nursing Interventions:	Expected Student Outcomes:
☐ Obtain parent and licensed prescriber authorization for medications to be given at school. ☐ Administer medication(s) as prescribed. ☐ Train staff who are responsible for the health care of the student during the school day on proper way to administer medication. ☐ Assess knowledge deficits and learning needs of staff related to management of chronic condition and medication administration for staff administering medications. Remediate when necessary. ☐ Other (specify):	☐ Student to have basic health needs met during the school day in order to attend school on a regular basis. ☐ Be able to verbalize whom they should contact if they were to experience side effects from their medication. ☐ Improved attendance. ☐ Other (specify):

☐ Signed by physician and parent	☐ Medication is appropriately labeled	☐ Medication Log generated

Notes:

*Student may carry some medication in certain circumstances. This applies to asthma medication, epinephrine auto-injectors, and diabetes medications, and ONLY after supplemental forms are completed and turned in to the school. *District and school medication policies have the final say on whether medication other than asthma medication, epinephrine auto-injectors, and diabetes medications can be self-carried.* ***(Note: Weber School District does not allow students in K-6th grade to self-carry and administer medications other than asthma medication, epinephrine auto-injectors, and diabetes medication.)***