BUENA VISTA CITY PUBLIC SCHOOLS
AUTHORIZATION TO ADMINISTER MEDICATIONS

1. Written orders using this form from a physician detailing the name of the drug and the specific information below is required.
2. Using this form, the signature of the parent or guardian requesting that the school district comply with the physician's order is to be obtained.
3. Medication must be brought to school by parent or guardian in the original container, appropriately labeled by the pharmacy or physician**. Medication in baggies will not be accepted**.
4. Schools are required to keep the medication in the original container (no pre-pouring is allowed) and under lock and key.
5. Any change of prescription requires a new written order from the prescribing physician.

Please fill in and sign this form:

Name of Student_____Allergies_____

Diagnosis_____Name of Medication_____

Dates medication must be administered at school: (check one)

_____Short Term (1-14 days) _____Episodic/Emergency Events Only

_____Every Day at School _____PRN (as needed)

Dosage_____Route_____Time of day _____

Can serious reactions occur if the medication is not given as prescribed?

_____Yes _____No

If yes, describe: _____

Serious reactions/adverse side effects from this medication may occur?

_____Yes _____No

If yes, describe:_____

Action/Treatment for reactions:_____

Report to you? _Yes_No

Special Handling Instruction: __Refrigeration__Keep out of sunlight

Other_____

Physician/Licensed Prescriber Name _____ Phone Number _____

Physician/Licensed Prescriber Signature_____Date _____

I request that the school give the above medication as ordered by the physician and I give my permission for the school to contact the physician's office regarding the medication should this be necessary.

_____ _____

Parent/Guardian Signature Daytime phone number