Fell Charter School Health Services
AUTHORIZATION FOR PRESCRIBED MEDICATION ADMINISTRATION (2025-2026)

Complete this form if your child has to receive prescribed medication (including over-the-counter) during the school day. This form requires both licensed provider and parent/guardian signatures. Certain conditions require an Emergency Action Plan. Contact the nurse.

Part 1: PHYSICIAN AUTHORIZATION (*filled out/signed by physician*)

Student Name:_____ **Age:**___ **Grade:**___
Diagnosis:_____

- **Medication:**_____
- **Dosage:**_____
- **Route:**_____
- **Time to Give:** _____
- **Side Effects:**_____
- **Duration of the order (school year or other):**_____
- **Special instructions/conditions to observe:** _____
- **If PRN, describe indications:**_____

LICENSED PROVIDER: Initial if applicable regarding self carry/administration.

_____This student **has permission** to carry and self-administer the above ordered asthma inhaler or epinephrine during school hours. He/she is qualified and has demonstrated the ability to self-administer.

LICENSED PROVIDER: INITIAL 1 OF THE CHOICES BELOW REGARDING FIELD TRIPS

During field trips the medication noted above may: **1)** _____Be omitted the day of the trip. **2)**_____Be given before/after the field trip. **3)**_____Be administered by parent/guardian or person authorized by parent/guardian accompanying the child on a trip.

Trained staff members may assist in the administration of Epi-Pen and/or asthma inhalers in an emergency situation.

_____ _____ _____

Date **Licensed Prescriber Signature (no stamps)** **Phone #**

_____

Licensed Prescriber's Printed Name

Part 2: To Parent/Guardian: I authorize Fell Charter School (nurse, principle or principal designee) to administer the medication as prescribed above. I do hereby release, discharge and hold harmless Fell Charter School and its employees, from any liability for any injury that may result out of the administration of the above medication in accordance with this request. I give permissions for the school and medical provider to communicate regarding this medication and medical condition.
□ ***My child is able and responsible to carry and self-administer his/her inhaler and/or epinephrine and has my permission for him/her to do so and to notify the nurse soon after using the medication.***

Parent/Guardian Signature _____ **Date**_____

Reviewed by School Nurse _____Date_____