

**ISLAND TREES SCHOOL DISTRICT  
PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF  
MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES**

**A. To be completed by the parent or guardian:**

I request that my child \_\_\_\_\_ DOB \_\_\_\_\_ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy\*.

**PLEASE CHECK AND INITIAL:**

I authorize an Island Trees staff member/chaperone to administer the following medications during field trips to my self directed child. (as determined by MD, school nurse and parent). \_\_\_\_\_

Signature (Parent or Guardian): \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Date \_\_\_\_\_

**B. To be completed by physician:**

I request that my patient, as listed below, receive the following medication:

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis: \_\_\_\_\_

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: \_\_\_\_\_

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_

**MD: PLEASE INITIAL EACH BOX THAT APPLIES:**

I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.

Child may self carry inhaler and/or epipen

Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\* Medication must be in original pharmacy labeled container with specific orders and name of medication.

\* Medication and refills must be brought to school by parent, guardian or responsible adult.