MICDS Authorization For Administration of Medication*

Please complete every item on this form.

STUDENT'S NAME:_____

Physician's Order

I have examined this student for (diagnosis):_____
and have determined she/he requires medication during school hours.

*MICDS upper and middle school students may have an Epi-pen, Insulin, Glucagon, or an inhaler in their possession, if the following authorization form is on file in the nurse's office. *PLEASE NOTE: all other medications must be kept in the nurse's office, respectively*.

- ❑ This student **should not** carry his/her medication by him/herself.
- ❑ The student **should** be allowed to carry and use medication by him/herself.

Name of Medication: _____ Dosage:_____

Name of Medication: _____ Dosage:_____

Directions for Administering Medication: _____

_____

_____

_____

_____

Administration period of above medication(s) (actual dates): From:_____ To:_____

Contact me if the following signs or symptoms appear: _____

_____

_____

Physician Signature: **X**_____**Date:**_____

Printed Name:_____ **Phone:**_____

Parent/Guardian Statement

I/We, the undersigned parent(s)/guardian(s) of _____
Request that the MICDS nurse or her designee administer the above named medication to this student according to the physician's instruction. I/We agree to furnish the necessary prescribed medication in a labeled pharmacy container and agree to notify the school nurse immediately if the physician or medication prescription is changed. The medication will remain at the school for the duration of the administration period.

Parent/Guardian Signature: **X**_____

Home Phone:_____