SCHOOL MEDICATION AUTHORIZATION FORM

J.E. Cosgriff Memorial Catholic School - Diocese of Salt Lake City

Student Name _____ Grade _____

To be completed by Healthcare Provider

This order can only be signed by Physician (MD, DO), Dentist, Nurse Practitioner (NP,FNP,PNP, APRN/PP), or Certified PA. Please provide **ONE** medication per form.

Name of medication _____

☐ Routine - Dose* _____ Time _____ Route _____

☐ PRN - Dose* _____ How Often _____ Route _____

***Please specify mg, mcg, ml, puffs, etc.**

Known side effects exhibited by student _____

_____

Possible side effects _____

Diagnosis _____

Medication Self-Administration Authorization: ☐ Yes ☐ No

The above named student is under my care. I feel it is medically appropriate and the student is trained and capable to carry and self-administer the following indicated medication at all times:

☐ Inhaler ☐ Insulin Pen ☐ Epi-Pen/Auvi-Q

Name of Healthcare Provider _____ Phone: _____

Healthcare Provider Signature _____ Date: _____

I hereby authorize J.E. Cosgriff office staff to administer the medication as listed above.

Parent Signature _____ Date: _____

Revised 8/2022