**MURRAY SCHOOL DISTRICT**
147 East 5065 South
Murray, UT 84107
(801) 264-7400

# STUDENT MEDICATION AUTHORIZATION FORM

## *STUDENT INFORMATION:*

_____
Student Name | Date of Birth | Grade

_____
Parent/Guardian | Home Phone | Work Phone

_____
Home Address | City/State | Zip Code

## *PHYSICIAN:*

_____
Name of Physician Prescribing Medication | Office Phone

_____
Physician's Business Address | City/State | Zip Code

## *MEDICATION:*

Reason for taking medication*:* _____

_____
Name of Medication | Dosage | Time(s) of Administration

Side Effects (if any): _____

_____

Procedure to follow in case of side effect/reaction: _____

_____

_____ _____
Physician Signature | Date

I give permission for school personnel to administer the medication identified above in the manner specified by the physician.

_____ _____
Parent/Guardian Signature | Date

# ASTHMA SELF-ADMINISTRATION FORM

Today's Date:_____

_____

Student Name Birth Date

_____

Address City State Zip

**EMERGENCY CONTACT INFORMATION:**

**Name:**_____ **Phone:**_____

**HEALTH CARE PROVIDER AUTHORIZATION**

The above-named student is under my care. I feel it is medically appropriate for the student to self-administer asthma medication and be in possession of asthma medication at all times. The medication prescribed for this student is:

Name of Medication: _____

Type of Medication (inhaler, tablet, etc.) _____

Dosage: _____

Possible Side Effects: _____

_____ _____

Signature of Health Care Provider Date

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**PARENT/GUARDIAN AUTHORIZATION**

- ❑ I authorize my child to carry and self-administer the medications described above consistent with UCA §53A-11-602.
- ❑ I do not authorize my child to carry and self-administer this medication. Please keep my child's medication with appropriate school personnel.

My child and I understand there are serious consequences, which may include suspension, for sharing any medication with others.

_____ _____

Parent/Guardian Signature Date