



# Soaring Skills, LLC. Medication Authorization Form

## 1. Student Information

Student full name

Date of birth

School Year

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent / Guardian

Primary phone

Emergency phone

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 2. Medication Information

Medication name

Reason / Diagnosis

\_\_\_\_\_

\_\_\_\_\_

Dose

Route

Time(s) to be given at school

Start date

End date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prescription

Yes

No / OTC

Requires refrigeration

Special instructions, side effects to monitor, or precautions

**Note: Medication must be provided in the original supplied bubble/blister/strip pack, and each dose must remain sealed and intact in the original packaging. Opened, damaged, altered, or partially used bubble/blister/strip packs will not be accepted.**

## 3. Parent / Guardian Authorization

I request that the above medication be administered to my child at school as directed.

I understand the medication must be supplied in the original labeled container, and I authorize the school nurse or trained school personnel to administer it according to this form and school policy.

Parent / Guardian signature

Printed name

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Email

Alternate contact

Phone

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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Have the prescribing provider complete this page when required by school policy or state law.

## 4. Licensed Provider Authorization

Student name \_\_\_\_\_ Medication \_\_\_\_\_ School year \_\_\_\_\_

Purpose of Medication \_\_\_\_\_ Medication Route \_\_\_\_\_ Frequency / exact time \_\_\_\_\_ Start date \_\_\_\_\_ End date \_\_\_\_\_

Purpose of Diagnosis

Special instructions, possible side effects, contraindications, or action to take for missed dose

Licensed provider name \_\_\_\_\_ Clinic / Practice \_\_\_\_\_ Phone \_\_\_\_\_

Provider signature \_\_\_\_\_ Fax \_\_\_\_\_ Date \_\_\_\_\_

## 5. School Use Only

Medication received by \_\_\_\_\_ Date received \_\_\_\_\_ Quantity received \_\_\_\_\_ Expiration date \_\_\_\_\_

Medication count verified  Yes  No      Stored in health office       Locked medication cabinet

Nursing notes / school comments

School nurse / staff signature \_\_\_\_\_ Printed name \_\_\_\_\_ Date \_\_\_\_\_