



Provider Medication Authorization Form

Student: _____ **DOB:** _____ **School Year** _____

Name of Medication	Reason for Medication	Medication Dosage & Strength	Route	Time(s) Medication to be Given
<input type="checkbox"/> Albuterol <input type="checkbox"/> Xopenex <input type="checkbox"/> Other Inhaler: _____	Asthma *Symptoms-(list): 1. _____ 2. _____ 3. _____	<input type="checkbox"/> 2 Puffs <input type="checkbox"/> Other: _____	<input type="checkbox"/> Inhaled <input type="checkbox"/> With Spacer	<input type="checkbox"/> Every 4 hours as needed for *symptoms <input type="checkbox"/> May repeat in _____ minutes if no relief (Notify RN) <input type="checkbox"/> Prior to exercise
Tylenol (Acetaminophen) <i>*only given for fever if student is going home</i>	<input type="checkbox"/> Headache <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Musculoskeletal pain <input type="checkbox"/> Toothache <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> 80 mg <input type="checkbox"/> 160 mg <input type="checkbox"/> 320 mg <input type="checkbox"/> 325 mg <input type="checkbox"/> 400 mg <input type="checkbox"/> _____	<input type="checkbox"/> Oral	<input type="checkbox"/> Every 4-6 hours as needed for ordered symptom

Physician's Signature: _____ **Date:** _____

Prescribing Physician's Name: _____ **Physician's Phone:** _____

School District Policy JLCD requires, as a condition to its agreement to release any medication, that the medicine be prescribed by a physician or dentist and furnished by the parent(s) of the student with the original pharmacy container label stating the student's name, name of the medication, the dosage, the number of doses per day or time(s) when the medication is to be released to the student, and the date when the medication is to be stopped (if applicable). It is understood that the medication is given solely at the request of, and as an accommodation to, the undersigned parent(s) or guardian(s). The undersigned parent(s) or guardian(s) hereby agree(s) to release the Douglas County School District RE-1 and its personnel from any and all claims), which they now have or may hereafter have arising out of the release of the medication to the student.

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____

Reviewed/complete Needs clarification