STUDENT HEALTH ALERT/AUTHORIZATION TO ADMINISTER MEDICATION

This form needs to be re-submitted each school year.

_____ _____/_____/_____

Student's Name (Last) (First) (Middle) Birth Date

If your child has health issues that are or could become emergent at school, we need to know about them. Please include anything we need to know about, including sensitivities and allergies. Please identify the nature and severity of the health issues and the interventions needed. Do NOT fill out this form if your student has no health issues that the school needs to know about.

Please outline the issue and the severity and frequency of this issue:

_____

_____

_____

Please tell us the prescribed intervention if this issue becomes emergent while the student is in school:

_____

_____

_____

If medicine is to be left in the office for emergencies, please give the needed information below:

_____ _____ _____ _____

Medication Dosage administer under these conditions Call 911? Yes/No

_____ _____

Intended effect of this medication Expected side effects

Administration Instructions:

_____

_____

_____

_____ _____

Prescriber's Signature Date

_____ _____ _____

Prescriber's Office Phone # Emergency Phone # Address

_____ _____

Parent/Guardian Signature Date