

School Name _____ Student's full name _____
First Last

MEDICATION AUTHORIZATION - Mill Hollow

Please enclose this signed form along with properly labeled medication in a re-closeable plastic bag and give it to the teacher at the time of student departure to Mill Hollow. State law prohibits teachers or Mill Hollow staff from administering medication of any kind without this completed, signed form.

I hereby authorize _____ to administer the medication
School Mill Hollow Teacher name
 described below to my child: _____
Child's name

I understand that the teacher or other District personnel will administer only the medication described below. If the prescription is changed, a new form for parent consent and a new physician's order must be completed before the school staff can administer the new medication.

Parent Signature: _____ Date: _____
 Phone number: _____ Emergency Number: _____

TO BE COMPLETED BY HEALTHCARE PROVIDER:

This order can only be signed by a licensed medical physician (MD, DO), certified physician's assistant, registered nurse, nurse practitioner (NP, FNP, PNP, APRN/PP) or licensed dentist.

Name of Medication	Dosage	Time	Route	For treatment of
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Side effects and special instructions: _____

Medication Self-Administration Authorization: () Yes () No

The above named student is under my care and has my approval to carry and self-administer the following indicated medication at all times: () Inhaler () Insulin Pen () Epi-Pen

Name of healthcare provider: _____ Phone: _____
 Healthcare provider signature: _____ Date: _____

TEACHER MEDICATION LOG

For Mill Hollow teacher use only

Date: _____	Date: _____	Date: _____			
Time(s):	Med's given:	Time(s):	Med's given:	Time(s):	Med's given:
•	•	•	•	•	•
•	•	•	•	•	•
•	•	•	•	•	•
•	•	•	•	•	•
•	•	•	•	•	•

Signature _____ Signature _____ Signature _____