MEDICATION AUTHORIZATION FORM

PARK CITY DAY SCHOOL

Student Name: **Grade:**

Authorization for Emergency Medication for Severe Allergic Reaction

Allergies: ____

List symptoms this student usually exhibits when have an allergic reaction:

____

____

If this student exhibits any of the above symptoms, or if ingestion of an allergen, exposure to an allergen or insect sting are suspected, IMMEDIATELY give:

☐ antihistamine ☐ Other

type:____________________ dose:_____________ type:______ dose:_____________

☐ Inhaler ☐ Epi Pen ☐ Epi Pen Jr.

type:____________________ dose:_____________ call 911 ☐ Yes ☐ No

If the student has trouble breathing, appears in distress or symptoms progress after giving the above medication, immdediately give:

☐ Epi Pen ☐ Epi Pen Jr.

call 911 ☐ Yes ☐ No

Physician's Signature: ____

Authorization to Administer Prescription Medication

Reason for Medication:____

____

Name of Medication	Dosage	Time to be Administered
______________________	________________________	________________________
______________________	________________________	________________________
______________________	________________________	________________________

Function Restrictions or Side Effects:

____

Duration Began on: _____________ Ends: _____________

Physician's Signature: ____

Authorization to Administer Asthma Medication

The above student has been diagnosed with asthma may require the following medication:

Via Inhaler

Drug: ________________________________

Dose: ________________________________

Frequency: ____________________________

Via Nebulizer

Drug: ________________________________

Dose: ________________________________

Frequency: ____________________________

Physician's Signature: ____