## MISSOULA COUNTY PUBLIC SCHOOLS

## Authorization for Medications or Treatments

(Order only medications/ treatments that are **required during** school hours)

## **Healthcare Provider Section**

Name of Student:		Date of Birth:		
School:			Grade:	
* Medication:			Dosage:	
* If medication is for asthma reso		ase use Asthma/ Quick ylaxis Action Plan forn		ication Authorization
Purpose of Medication:				
Administration time of medicati				
If medication or treatment is no	t taken at the above ti	me (+/- 30 minutes), I	now late may it still be give	n?
Possible side effects:				
Duration of Order: Valid until en	d of school year unless	otherwise noted. <b>Oth</b>	er length of duration:	
Provider Signature	Date	Phone	PRINTED N	NAME OR STAMP
*********	*******	******	*******	*******
Parent/Guardian Secti	ion			
<ul> <li>I give my permission for</li> </ul>	the above named stud	dent to take the above	medication at school as ord	dered.
	=	•	I nurse or a school staff me	mber.
I will bring the medication	•	•		
	·		d to do so by law or specific	•
of the medication, the	=		riately labeled by the pharm	iacy stating the name
	=		ts original container with la	bel intact.
<ul> <li>I agree to health care pr</li> </ul>	rovider (doctor) and sch	hool nurse communica	tion based on this medical	authorization if
needed. Communication	n, if needed, may only i	include the medicatior	or treatment itself, implen	nentation of the
treatment in school and				
<ul> <li>I understand that I need school year or after one</li> </ul>			will discard the medication	at the end of the
school year of after one	month of discontinuin	· 6·		
	Parent/Guardian Sig		Date	
	*******	******	*********	******
School Nurse Section				

School Nurse Signature

Date Order Reviewed

Revised December 2017