MURRAY SCHOOL DISTRICT
5102 S Commerce Dr - Murray, UT 84107
801-264-7400

STUDENT MEDICATION AUTHORIZATION FORM

STUDENT INFORMATION:

Student Name	Date of Birth	Grade
Parent/Guardian	Home Phone	Work Phone
Home Address	City/State	Zip Code

PHYSICIAN:

Name of Physician Prescribing Medication		Office Phone
Physician's Business Address	City/State	Zip Code

MEDICATION:

Reason for taking medication*:* _____

Name of Medication	Dosage	Time(s) of Administration

Side Effects (if any): _____

_____

Procedure to follow in case of side effect/reaction: _____

_____

Physician Signature	Date

I give my permission for school personnel to administer the medication identified above in the manner specified by the physician.

Parent/Guardian Signature	Date

ASTHMA SELF-ADMINISTRATION FORM

Today's Date:_____

_____

Student Name Birth Date

_____

Address City State Zip

EMERGENCY CONTACT INFORMATION:

Name:_____ **Phone:**_____

HEALTH CARE PROVIDER AUTHORIZATION

The above-named student is under my care. I feel it is medically appropriate for the student to self-administer asthma medication and be in possession of asthma medication at all times. The medication prescribed for this student is:

Name of Medication: _____

Type of Medication (inhaler, tablet, etc.) _____

Dosage: _____

Possible Side Effects: _____

_____ _____

Signature of Health Care Provider Date

PARENT/GUARDIAN AUTHORIZATION

- ❑ I authorize my child to carry and self-administer the medications described above consistent with UCA §53A-11-602.
- ❑ I do not authorize my child to carry and self-administer this medication. Please keep my child's medication with appropriate school personnel.

My child and I understand there are serious consequences, which may include suspension, for sharing any medication with others.

_____ _____

Parent/Guardian Signature Date