

**This form needs to be printed, taken to the doctor for signature, completed, and sent or faxed to school. The fax number is 486-4732. Please fill out one form per child.  
This form cannot be sent directly to school because a signature is required.**

Authorization for the Administration of Medicines by School Personnel

The NEBRASKA State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse to administer medication, or in her absence, the designee to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, physician's or dentist's name and the date of original prescription.

**Physician's or Dentist's Order**

Name of Child:  Date:

Address:

Date of Birth:

Condition for which drug is being administered during school hours:

DRUG name, dose, and method of administration:

Time of administration:

Medication shall be administered from  to

Relevant side effects to be observed, if any:

If there are side effects, plan for management:

Is this a controlled drug?  Yes  No If yes, DEA Number:

Physician's/Dentist's Name:  Telephone Number:

Address:

(Self-administration of Inhalant Drugs--Secondary Students Only)

Do you feel this student can self-administer without direct supervision?  Yes  No

Physician's/Dentist's Signature:  Date:

Nurse/Principal/Teacher:  Date:

Authorization by Parent/Guardian for the Administration of the above medication by School Personnel:

To School Personnel:  Date:

I hereby request that the above medication, ordered by the physician/dentist for my child (name)  be administered by school personnel. I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 45 school day supply of said medication.

I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Name:

Signature:  Relationship to child:

Address:  Telephone Number: