Intermediate District 287

RESPONSIVE. INNOVATIVE. SOLUTIONS.

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Student Name: ____ Date of Birth: _____/_____/____

Allergies: ____

District 287 policy requires a written order with signatures from both the provider and the parent/guardian before a medication can be administered by school personnel. This must be done with each new school year. ***Medical marijuana cannot be administered by school nurses or on school grounds.***

PROVIDER: Complete the table below with medication to be administered while student is at school. Please include both the diagnosis and ICD-10 code for which this medication is prescribed, as this is necessary for our billing purposes.

Time	Medication	Dose	Diagnosis	ICD-10 code	Date Start	Date End

Comments:

Provider name (please print): ____

Clinic: _______________________________________ Phone number: _________________________

Provider signature: ____ Date: _____________

PARENT /GUARDIAN: Please have provider complete and sign this form before sending to school. Medications must be sent in original container. Contact the health office at your student's school with any questions or concerns.

Parent/Guardian name (please print): ____

Parent/guardian signature: ____ Date: ______________