School Name _____ Student's full name _____
(*First Name Last Name)*

MEDICATION AUTHORIZATION - Mill Hollow

Please enclose this signed form along with properly labeled medication in a re-closeable plastic bag and give it to the teacher at the time of student departure to Mill Hollow. State law prohibits teachers or Mill Hollow staff from administering medication of any kind without this completed, signed form.

I hereby authorize _____to administer the medication described
(Group Leader/School Teacher name)
below to my child: _____
(Child's name)

I understand that the Group Leader or other Mill Hollow personnel will administer **only** the medication described below. If the prescription is changed, a new form for parent consent and a new physician's order must be completed before the school staff can administer the new medication.

Parent Signature: _____Date: _____

Phone number: _____ Emergency Number: _____

TO BE COMPLETED BY HEALTHCARE PROVIDER:

This order can only be signed by a licensed medical physician (MD, DO), certified physician's assistant, registered nurse, nurse practitioner (NP, FNP, PNP, APRN/PP) or licensed dentist.

Name of Medication **Dosage** **Time** **Route** **For treatment of**

_____

_____

_____

Side effects and special instructions:_____

_____

Medication Self-Administration Authorization: ( ) Yes ( ) No

The above named student is under my care and has my approval to carry and self-administer the following indicated medication at all times: ( ) Inhaler ( ) Insulin Pen ( ) Epi-Pen

Name of healthcare provider: _____ Phone:_____

Healthcare provider signature: _____ Date: _____

TEACHER MEDICATION LOG:

(For Mill Hollow Group Leader/Teacher Use Only)

Date:_____		Date:_____		Date:_____	
Time(s):	Meds Given:	Time(s):	Meds Given:	Time(s):	Meds Given:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Signature_____ Signature_____ Signature_____