SWWC
EDUCATIONAL LEARNING CENTERS

Medication/Treatment Authorization Form

PARENT – PLEASE COMPLETE

Communication between the medical community and SWWC - ALC provides for positive health outcomes for children, families and community. Completing and returning this form to the nurse at your child's ALC enhances coordination of services and promotes an optimal learning environment.

☐ Please fax this form to my child's nurse (Fax number: _____)

☐ I will provide this form to the nurse at _____ (please specify SWWC - ALC location) for the individualized treatment plan interval _____ to _____ (please specify time frame)

1. I request that the medication(s) and/or treatment(s)/procedure(s) specified on this form be given during SWWC - ALC hours as ordered by this child's physician/licensed prescriber.
2. I release SWWC - ALC personnel from liability in the event adverse reactions result from the medication(s) and/or treatment(s)/procedure(s).
3. I will provide SWWC - ALC with physician/licensed prescriber authorization for any change in medication(s) and/or treatment(s)/procedure(s). (Example: dosage change, time change, discontinued, etc.)
4. I give permission for the nurse to communicate with the child's SWWC - ALC staff about my child's health condition (s) and the action of the medication(s) and/or treatment(s)/procedure(s).
5. I give permission for the nurse to consult (both verbally and in writing) with the above named child's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s)/treatment(s)/procedure(s) being used to treat the condition.
6. I give permission for the medication(s)/treatment(s)/procedure(s) to be given by designed personnel as delegated by the nurse.
7. I understand that school health personnel cannot administer the medication(s) /treatment(s)/procedures(s) indicated on this form without authorization from my child's physician/licensed prescriber.

Additional Information:

_____ _____ _____

Date | Parent/Legal Guardian Signature | Relationship to Child

Child's Name: _____ DOB: _____

2021-06-09 ML

SWWC
EDUCATIONAL LEARNING CENTERS

Communication Record Medication/Treatment Authorization Form

PHYSICIAN/LICENSED PRESCRIBER – PLEASE COMPLETE

Diagnosis/Significant Findings:

History:

Allergies:

Medication Required During School Hours					
Medical Condition	Medication	Strength	Time	Route	Possible Side Effects
1.					
2.					
3.					

**** Medication is to be supplied in the original manufacturer or prescription container. ****

Treatments/Procedures Required During School Hours (e.g., Peak flows, blood glucose monitoring, catheterization, suctioning, ventilator care, dressing changes, etc.)			
Medical Condition	Treatment/Procedure	Time(s)/Frequency	Special Instruction
1.			
2.			

Child's Name: _____ DOB: _____

ADDITIONAL INFORMATION

☐ Child may carry/self administer his/her inhaler.

☐ Child may carry/self administer his/her epi-pen injector.

☐ Child may carry/self administer _____ (*Please identify*)

☐ Return to school with NO limitations on _____.

☐ REST AT HOME through _____ or until next scheduled visit.

☐ MODIFY the following activities during SWWC - ALC hours through _____ or until next visit.

- ☐ Physical Education
- ☐ Ambulation
- ☐ Sports
- ☐ Diet

Please specify:

_____ _____ _____

Date | Print Name of Physician/Licensed Prescriber | Physician's/Licensed Prescriber's Signature

_____ _____

Clinic Name and Address | Telephone Number

Child's Name: _____ DOB: _____