School Year: _____ - _____

RICHLAND School District

MEDICATION AUTHORIZATION FORM

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the school - may not exceed a 20 day supply.

STUDENT NAME: _____ BIRTHDATE _____ SCHOOL _____

MEDICAL PROVIDER INSTRUCTIONS: To be completed by the medical provider –i.e. MD/DO/NP/DDS

MEDICINE NAME (only one medication per form)	**DOSAGE**	**ROUTE**	**TIME / FREQUENCY**
		☐ ORAL ☐ EYE DROP ☐ TOPICAL ☐ EAR DROP	

REASON FOR MEDICATION: _____

IF PRN, FOR WHAT SYMPTOMS: _____

FURTHER INSTRUCTIONS: (Possible reactions, etc.) _____

☐ Self Carry: (High School only)

I request that the above named student be allowed to have personal possession of the above medication and be permitted to self administer this medication within RSD policy and prescription instructions. Student may only self-carry single day dose of medication.

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above. This medication order shall be effective for the current school year or for the period commencing the _____day of _____, 20_____ through the _____ day of _____, 20_____ (not to exceed the current school year). A health condition makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

MEDICAL PROVIDER SIGNATURE: _____ **DATE:** _____

_____ _____ _____

PROVIDER NAME (PLEASE TYPE OR PRINT) **PHONE** **FAX**

♦ **<u>This form is not intended for rescue inhalers, epinephrine, or insulin</u>.** If the student has a life-threatening diagnosis (i.e. Asthma, Anaphylaxis, Diabetes, Epilepsy), please complete the RSD medical form specific to the condition (ie. *Medical Form – Asthma*). RSD medical forms may be downloaded at http://www.rsd.edu/departments/student-health-forms.html

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THIS PORTION MUST BE COMPLETED BY THE PARENT OR LEGAL GUARDIAN

I request designated school personnel to administer the medication as prescribed by the above prescriber and in accordance of RSD medication policy. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the mediation, otherwise it will be discarded. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

PARENT SIGNATURE: _____ **DATE:**_____

Parent/Guardian Contact Information:

Name: _____ Home: _____ Cell: _____ Work: _____

Name: _____ Home: _____ Cell: _____ Work: _____

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Order reviewed by the school RN: _____ _____
Signature **Date**

Principal approval for self-carry/self-administration of medication: _____ _____
Signature **Date**