



Authorization for Administration of Medication at School

Name of Student: _____ Birthdate: _____

School: _____ School Year: _____ Grade: _____

Medical Condition & ICD 10 Code	Medication Name and Strength	Dose	Time	Route	Possible Side Effects

Other Considerations/Directions: _____

- ☐ Student is knowledgeable about the medication and how to administer it
- ☐ Student may self-administer the medication (not applicable for controlled substances)

Start Date: _____ All authorizations expire at end of the school year unless noted: _____

Print/Type Name of Physician/Licensed Prescriber

Physician's/Licensed Prescriber's Signature

Clinic Name & Location

Phone Number

Fax Number

Date

PARENT/GUARDIAN AUTHORIZATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber.
2. I also request the medication(s) be given on field trips, as prescribed.
3. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
4. I will notify the school of any change in the medication(s) such as dosage change, discontinued, etc.
5. I give permission for the School Nurse to consult with the above named Physician/Licensed Prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
6. I give permission for the medication(s) to be given by designated personnel as delegated by the School Nurse.

- ☐ My child may self-administer their medication (not applicable for controlled substances)

Date

Parent/Guardian Signature

Relationship to Student

Note: MEDICATION MUST BE SUPPLIED IN THE ORIGINAL/PRESCRIPTION BOTTLE & CANNOT BE EXPIRED



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MEDICATION PROCEDURE

The purpose of administering medications in school is to assist students who require medication to be taken or administered during school hours to maintain an optimal state of health, therefore, enhancing their educational program.

The intent of this procedure is to assure safe administration of medications in school for those students who require them. This procedure applies to both prescription and over-the-counter medication.

A written statement shall be required annually.

LONG-TERM MEDICATIONS: Prescribed for more than two weeks

1. A written statement is required:
 - a. From the physician indicating the name of the medication, the route, the dosage, frequency and time of administration, reason the medication needs to be given (diagnosis), possible side effects, and termination date.
 - b. From the parent requesting and authorizing the school to give the medication in the dosage prescribed by the physician.
2. Parents/guardians are required to supply the medication in the original container labeled by the pharmacy or physician. The container will be labeled with the student's name, name of the medication, dose to be given, frequency and time it is to be given, the name of the prescribing physician and the date the medication was obtained.

SHORT - TERM MEDICATIONS: Prescribed for less than two weeks

1. A written statement will be required from the parent/guardian giving permission to give the medication in school. The statement must include: the name of the medication, the reason for the medication, the route, the dosage, the time and date the medication is to be given.
2. Parents/guardians are required to supply the medication in the original container labeled by the pharmacy or physician. The container will be labeled with the student's name, name of the medication, dose to be given, frequency and time it is to be given, the name of the prescribing physician, and the date the medication was obtained.