SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current): _____including the summer session.

School: _____

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 medication.

* Prescription medication(s) must be in a container labeled by the pharmacist or prescriber - with the students' name printed on the label.
* Non-prescription (over-the-counter) medication(s) must be in the original unopened container with the label and seal intact.
* An adult must drop off and pick up the medication at the school office.
* The school nurse (RN) will call the prescriber, as allowed by HIPPA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student:_____ Date of Birth: _____Grade: _____

Medication Name: _____ Dose: _____Route: _____

Condition for which medication is being administered: _____

Time/Frequency of administration: _____If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐None expected ☐Specify: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____
(Type or Print)

Telephone: _____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

_____

PARENT/GUARDIAN AUTHORIZATION

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

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____Work Phone #: _____

_____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of emergency medication may be authorized by the medical prescriber and must be approved by the school nurse according to the state's medication policy.

Prescriber's authorization/signature for self-carry/self-administration of emergency medication: _____ Date: _____

School RN approval/signature for self-carry/self-administration of emergency medication: _____ Date: _____

Order reviewed by the school RN: _____