School Medication Administration Authorization Form

This order is valid only for school year (current)_____, including summer session.
School:_____
This form must be completed fully in order for school 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 must be in a container labeled by the pharmacist or prescriber.
- ★ Non-prescription (over the counter) medication must be in the original container with the label intact. Students' names and date of birth must be on the medication.
- ★ Over the counter medications, except topical creams/ointments, require physician signature.
- ★ An adult must bring the medication to school. Any controlled substance must be counted with the parent and a staff member.
- ★ If a controlled substance is permitted for self carry, only the daily dose(s) needed are allowed to be carried.

Prescriber's Authorization

Name of Student:_____ Date of Birth:_____ Grade:_____

Condition for which medication is being administered:_____

Medication Name:_____ Dose(no ranges):_____ Route:_____

Time/frequency of administration:_____ If PRN(as needed), frequency:_____

If PRN(as needed), for what symptoms: _____

Special administration instructions:_____

Relevant side effects: ▢ None Expected ▢ Specify:_____

Special storage requirements: ▢ None ▢ Refrigerate ▢ Other:_____

Medication Shall be administered from:(Month/day/year):_____ to _____

Prescriber's Name/Title:_____

Telephone:_____ Fax:_____

Address:_____

Prescriber's Signature:_____

Date:_____

Parent/Guardian Authorization

I/We request 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. I/We authorize the school personnel to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature:_____ Date:_____

Home/Cell Phone #:_____ Work Phone #:_____

Self Carry/Self Administration of Medication Authorization/Approval

Self carry/self administration of medication (including **emergency medication**) may be authorized by the prescriber and parent.

This student may carry this medication: ▢ Yes ▢ No

This student is both capable and responsible for self-administering this medication:

▢ Yes, supervised ▢ Yes, unsupervised ▢ No

Prescriber's authorization for self carry/self administration of medication: _____
Signature/Date

Parent's approval for self carry/self administration of medication:_____
Signature/Date