2007 AR (Medication) Authorization to Administer Medication

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 medication is permitted for self carry, the student may only carry one-day's worth of medication dose/s.

Prescriber's Authorization (To be completed by authorized prescriber)

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

Condition for which medication is being administered:_____

Medication Name:_____ Dose(no ranges):_____

Route: ▢ By Mouth ▢ Inhaled ▢ Injection ▢ Other:_____

Time/frequency of administration:_____ If as needed, frequency:_____

If 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. High school students may self administer medication. Elementary and middle school students may self administer only emergency medications.

This student may carry this medication: ▢ Yes ▢ No

This student is capable and responsible for self-administering this medication: ▢ Yes ▢ supervised ▢ 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