MEDICATION ADMINISTRATION AUTHORIZATION

Learner Name_____ **Date of birth**___/___/_____

Allergies_____ **School**_____ **Grade / Teacher**_____

Over the counter (OTC): (Dose/directions must match label on manufacture bottle or will require provider signature)

Medication Name (Generic/Trade)	Dose	Route	Time / Frequency / Indication	Special instructions or side effects
1				
2				
3				

****** If applicable: Authorized to self-administer unsupervised YES / NO -- Authorized to carry med YES / NO
If yes, list meds _____ Location _____

Prescription Medication: (Dose and directions must match pharmacy label on bottle)

Medication Name (Generic/Trade)	Dose	Route	Time / Frequency / Indication	Special instructions or side effects
4				
5				
6				

****** If applicable: Authorized to self-administer unsupervised YES / NO -- Authorized to carry med YES / NO
If yes, list meds _____ Location _____

Provider Name_____ **Location**_____

Phone_____ **Fax**_____

Provider Signature X_____ **Date**_____

(Computerized medication list will be accepted with provider name and date)

I authorize the school nurse or designated personnel to contact the prescriber as needed to obtain or clarify health information and share information outlined in this plan with individuals working within the school who need to know for the purpose of providing safe medication administration and appropriate learner care. I agree to notify the school immediately if my child's health status changes, or there is a change or cancellation of this medication. I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the learner's health record.

☐ I authorize designated school personnel to administer the medication(s) as described or written by his/her licensed prescriber during school hours. I, or a responsible adult, will review the district medication policy and will bring no more than a 30-day supply of prescription medication(s) to school in a labeled pharmacy or manufacturer container.

☐ I authorize _____ to self-administer the medication(s) as described above or written by the licensed prescriber. I, or a responsible adult, will review the medication policy and administration procedure with my learner to ensure understanding and competency to safely self-administer their medication(s) as prescribed or directed on the manufacture's container. I acknowledge and understand school personnel will not be involved in the administration of these medications and will not be monitoring the learner for side effects or failure to take the medication. Designated school personnel reserve the right to examine the medication container at any time and may revoke privileges to self-administer any medication(s) not being used or maintained properly by the learner.

Furthermore, by signing I understand I can revoke this authorization at any time in writing and agree to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the administration of cares and/or treatments to the above-named learner from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused, or claimed to be caused or to result from care in accord with the above "Medication Administration Authorization".

Parent/Guardian Name_____

Phone: (H)_____ **(C)**_____ **(W)**_____

Alternate Contact Name_____

Phone: (H)_____ **(C)**_____ **(W)**_____

Parent /Guardian Signature X_____ **Date**_____

Learner Signature X_____ **Date**_____
(Required to self-administer medication)

Office Use Only: (Controlled substances require pill count)

Medication(s) were hand delivered in a labeled container by: _____

1. Quantity _____ Expiration Date _____ Verified orders and has applicable signatures Y / N
2. Quantity _____ Expiration Date _____ Verified orders and has applicable signatures Y / N
3. Quantity _____ Expiration Date _____ Verified orders and has applicable signatures Y / N

4. Quantity _____ Expiration Date _____ Verified orders and has applicable signatures Y / N
5. Quantity _____ Expiration Date _____ Verified orders and has applicable signatures Y / N
6. Quantity _____ Expiration Date _____ Verified orders and has applicable signatures Y / N

Reviewed / Accepted by:_____ Date _____