Nixa Schools Health Services

Authorization of Administration of Medications to Students

Please attach any additional information the district might need to have in an emergency.

School____Date Form Received by the School_______________

<u>Student Information</u>

Name____Age________DOB________________
Teacher/Homeroom____Grade_____________

<u>Medication Information</u> *Medications must be in the original prescription or over-the-counter container and provided to the school nurse by a parent/guardian or specified adult.*

Prescription Medication   Over the Counter Medication (Provided by Parent/Guardian)

Has the student been given the first dose of this medication?   Yes   No

Name of Medication ____
Reason for Medication____

Form of Medication: Tablet/Capsule   Liquid   Inhaler   Injection   Nebulizer

Other ____

Dose__________________________________Time(s) to be given at school___________________________________
If "as needed", indicate the maximum dosage per day ____

Are the restrictions and/or important side effects?   Yes   No
If yes, please describe____

Special Storage Requirements   None   Refrigerate   Other__________________________________

Pharmacy______________________________________Prescription Number___________________________________

<u>Ordering Physician Information</u> *The prescription label may be considered the equivalent of a prescriber's written order.*

Physician Signature____Date________________________________
Physician Name_________________________________Phone______________________Fax______________________

<u>Parental Permission</u>

I give permission for ____________________________________ (student's name) to receive the above medication at school. I also give the district employees permission to contact the student's physician directly to provide information on the student's condition or to clarify medication administration instructions. I understand that I have the ultimate responsibility for providing the school with adequate supply of medication and for informing the school district immediately if any information provided on this form changes or if administration of medication should cease. I understand that at the end of the school year, an adult must pick up the medication; otherwise it will be discarded.

Signature____Date___________________________
Relationship______________________ Primary Phone___________________Secondary Phone____________________

Note: ***The reader is encouraged to review policies and/or procedures for related information in this administrative area.***