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Parent/Guardian Authorization and Medication Administration Plan

Student Name: _____ DOB: _____ Grade: _____ Team / HRM: _____

Student Address: _____
Street Apt/Suite City/Town State Zip Code

Name of Licensed Prescriber: _____ Title: _____

Prescriber Business Phone: _____ Prescriber Emergency Phone: _____

Parent/Guardian Name: _____ Home Phone: _____ Cell: _____

Work Phone: _____ Emergency Phone: _____

(Other person to contact in case of emergency) Name: _____

Relationship to student: _____ Cell Number: _____ Work Number: _____

Does student have food/drug allergies? Please list: _____

Diagnoses: _____
(if not in violation of confidentiality)

Name of Medication: _____ Will this medication be given on half/early release days? _____

Date ordered: _____ Duration of order: _____ Dosage: _____

Frequency: _____ Route of administration: _____ Expiration of med received: _____

Specific directions (e.g., times to be given; takes with applesauce, etc.): _____

Possible side effects/adverse reactions: _____

Other medications being taken by the student: _____
(if not in violation of confidentiality)

Location where medication administration will occur: ☐ Nurse's office ☐ Other: _____

Plan for monitoring medication, if needed: _____

I consent to have the school nurse or school personnel designated by the School Nurse administer medication. INITIAL _____

I give permission for my child to self-administer medication, if the school nurse determines it is safe and appropriate. ☐ Yes ☐ No INITIAL _____

I give permission to the School Nurse to share information relevant to the prescribed medication administration as the School Nurse finds appropriate for the child's health and safety. INITIAL _____

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following the termination of the order or beyond the close of school. INITIAL _____

Parent/Guardian Name: _____ Parent/Guardian Signature: _____

Relationship to student: _____ Today's Date: _____

School Nurse Name: _____ School Nurse Signature: _____ Date: _____

Today's Date: _____ Medication & Dosage Received: _____ Quantity: _____ Signatures of both parent/guardian & RN _____

MEDICATION PLAN

CONSENTS

/			
Today's Date:	Medication & Dosage Received:	Quantity:	Signatures of adult delivering med / School RN
Amount of meds on hand prior to delivery	Current total # of meds	Relationship of adult delivering medication for student	
/			
Today's Date:	Medication & Dosage Received:	Quantity:	Signatures of adult delivering med / School RN
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