SCHOOL MEDICATION AUTHORIZATION ORDER STUDENT HEALTH PLAN Utah Department of Health in Accordance with UCA 53G-9-501 *Do not use this form for Epinephrine Auto-Injectors, Glucagon, Inhalers, Insulin, or Seizure Rescue Medication* ***THIS FORM IS ONLY FOR MEDICATION THAT IS ADMINISTERED AT SCHOOL***	**PHOTO**	CACHE COUNTY SCHOOL DISTRICT Nursing & Health Services Phone 435-752-3925 Fax 435-792-7796	RN Approval Date:

STUDENT **INFORMATION**				
Student:	School:	Grade:	SY:	DOB:
Parent:	Phone:		Email:	
Prescriber Name:	Phone:		Email:	
School Nurse:	Phone:		Email:	

PARENT STATEMENT AND SIGNATURE

As parent/guardian I request and authorize the medication(s) listed below be given to my student during regular school hours.

I UNDERSTAND:

- Medication will be administered by trained school employee volunteers.
- A new medication authorization form will be required each school year, and whenever there is a dosage change.
- Parent or guardian is responsible for maintaining necessary supplies, medications, and equipment.
- All medication must be transported to and from the school by an adult*****.
- Prescription medication must be in the current original pharmacy container/label, with the child's name, medication name, administration time, dosage, and health care provider's name.
- Over-the-counter medication must be in the original manufacturer container.
- The information contained in this order will be shared with school staff on a need-to-know basis.
- It is my responsibility to notify the school nurse of any change in my student's health status, care, or medication order.
- Expired medication cannot be accepted or administered to my student.

I give permission for my child's healthcare provider to share information with the school nurse for the completion of this order.

Parent Signature:_____ **Date:**_____

MEDICATION INFORMATION

If a request is being made for school staff to administer asthma medication, epinephrine auto-injector, diabetes medication, or seizure rescue medication, an additional specific form(s) will be required, and must be signed by the parent and physician, and kept on file at the school. These supplemental forms will also be required for students who carry and self-administer asthma medication, epinephrine auto-injectors, and diabetes medications. Seizure rescue medication cannot be carried by a student.

Name of Medication	Diagnosis	Dosage	Route	Time	Side Effects

Additional Instructions to the School:

Medication will be kept: ☐ In the office ☐ In the classroom ☐ Other:

PRESCRIBER STATEMENT AND SIGNATURE

This form must be signed by **prescriber** (i.e. ongoing caregiver) to be valid, and can only be signed by an MD/DO; Nurse Practitioner, Certified Physician's Assistant or a provider with prescriptive practice.

The above-named student is under my care and I have prescribed this/these medication(s) for that student. It is medically necessary for medication administration while the student is under the control of the school.

☐ Student has diagnosis of: _____.

☐ It is medically appropriate for the student to self-carry* this medication, when able and appropriate, and be in possession of this medication and supplies at all times (see statement above under Medication Information). This student has been trained to self-administer the medication and is capable of doing this safely.

☐ It is not medically appropriate to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain this

This authorization order is effective for one year from licensed medical provider's signature date or earlier stop date _____. This document is not valid and no specific accommodations will be made until signed by all parties.

Name	Signature	Date
Prescriber:		
School Nurse:		
Principal:		

SCHOOL HEALTH PLAN

- The above-named student requires medication to be administered during school hours. District office policy, protocols and CCSD Medication Administration Training manual must be followed for all medication administration. Obtain parent & prescriber authorizations for medications to be given at school.
- Before administering medication to the student, you must always verify that you have the right student, the right time, the right medicine, the right dose, the right route, and complete the right documentation. Administer medication as prescribed. Always document using the CCSD approved documentation forms written or electronic.
- Always observed the student for any side effects or allergic reactions after administration of medication.
- Notify the school nurse with any questions, concerns or errors immediately.
- The school nurse will provide training for all designated employees on a yearly basis or as needed. RN will assess knowledge deficits & learning needs of staff related to administering medications. Remediate when necessary.
- Medications may be administered by the school nurse or designated trained employees. The school nurse will monitor medication administration.

EXPECTED STUDENT OUTCOMES

- Student to have basic health needs met during the school day in order to attend school on a regular basis.
- Be able to verbalize whom they should contact if they were to experience side effects from their medication.

To be complete by School Nurse (or principal designee if no school nurse)

☐ Signed by physician and parent	☐ Medication is appropriately labeled	☐ Medication Log generated

Notes:

***Students may carry self-carry medication in certain circumstances. This applies to adrenal crisis medication, asthma medication, epinephrine auto-injectors, and diabetes medications, and ONLY after supplemental forms are completed and turned in to the school. The district medication policy determines whether medication other than adrenal crisis medication, asthma medication, epinephrine auto-injectors, and diabetes medications can be self-carried.**