AUTHORIZATION TO ADMINISTER MEDICATION

This order is only valid for School Year:_____

This form must be completed fully and annually for *all medications* and each time there is a change in dosage, frequency, or time of administration of a medication in order for U of D Jesuit to administer the medication. A prescriber's signature must be on this form, even for medications purchased over the counter.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- Please check expiration dates of medications prior to bringing them to school.
- An adult must bring the medication to the school and hand it directly to the school nurse accompanied by this form.
- The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

PRESCRIBER'S AUTHORIZATION *(this section to be completed by the prescriber)*

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

Condition for which medication is being administered: _____

Medication Name:_____ Dose:_____ Route: _____

Expiration Date: Time/frequency of administration: _____ if PRN, frequency: _____

If PRN, for what symptoms: _____ Relevant side effects, specify if any:_____

Medication shall be administered from _____ to _____
Month/Day/Year Month/Day/Year

Additional Medication (if **applicable):**

Condition for which medication is being administered: _____

Medication Name:_____ Dose: _____ Route: _____ Expiration Date:_____

Time/frequency of administration: _____ if PRN, frequency: _____

If PRN, for what symptoms: _____ Relevant side effects, specify if any: _____

Medication shall be administered from _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____

Telephone: _____ Fax: _____

Address: _____

Prescriber's Signature: _____
(Original signature or signature stamp only)

Use for prescriber", address

PARENT/GUARDIAN AUTHORIZATION *(this section to be completed by the parent/guardian)*

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 school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the healthcare provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone#: _____ 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 must be approved by the school nurse according to the school medication policy.

This student is both capable and responsible for self-administering this medication: NO_____ Yes, Supervised_____ Yes, Unsupervised_____

Prescriber's authorization for self-carry/self-administration of medication: _____
Signature Date