



PRESCRIPTION MEDICATION AUTHORIZATION

Please take this form to your child's licensed primary care provider for completion. Use a separate form for each prescription medication.

Medications may be administered only with authorization by a licensed primary care provider (physician, nurse practitioner, or dentist) and written consent from the parent/guardian. The parent/guardian is responsible for obtaining the authorization of the licensed primary care provider as well as providing the specific medication to be administered to the school nurse. All information and supplies needed for the proper administration of the medication and a current form must be on file at the School. We suggest that parents obtain this authorization at the time of the annual physical and/or prior to the start of each school year. Medication requests must be renewed annually. Any changes to dosage or frequency require a new form including the signature of the licensed primary care provider.

Medication Authorization/Primary Care Provider's Order

(To be completed by the Licensed Primary Care Provider)

Student Name: _____ Grade: _____ Date of Birth: _____ Gender: M F

Date of Order: _____ Order Expires (check one): ☐ End of School Year ☐ End of Summer ☐ ____/____/____

Allergies: _____

Name of Medication: _____ Dose: _____ Route: _____

Time to Give Medication: _____ Frequency of Medication (if "as needed"): _____

Reason for Medication: _____

Possible Side Effects: _____

Student may carry and self-administer emergency medication: ☐ Yes ☐ No

Primary Care Provider Name (please print): _____

Primary Care Provider Signature: _____

Primary Care Provider Telephone Number: _____

I/We hereby give permission for _____ to take the medication described above at School as ordered by his/her Primary Care Provider identified above. I/We understand that it is my/our responsibility to furnish the medication and any authorized refills. I/We further understand that National Presbyterian School, its officers, agents and/or any employee who administers any medication to my/our child, in accordance with written instructions from the prescribing licensed primary care provider shall not be liable for damages as a result of an adverse drug reaction or any other injury suffered by my/our child due to the administration or failure to provide the drug. National Presbyterian School reserves the right to not administer medication should circumstances warrant such actions. I/We understand that the medication must be brought to the School in the current pharmacy labeled container (prescription) by me/us. Pharmacy labels should not be altered and must include the child's full name and date of birth. Medications may not be expired or in a pharmacy container past the expiration date.

Name of Parent/Guardian (please print): _____

Signature of Parent: _____ Date: _____

Office Use Only:

- ☐ Pharmacy label & Licensed primary care provider orders match
- ☐ Orders signed by Licensed primary care provider & Parent/Guardian

RN Signature: _____ Date: _____