



Medication Authorization for Students

Student's Name: _____ Date of Birth: _____

School Year: _____ Teacher/Grade: _____

To keep this student in optimum health, to help maintain maximum school performance, and/or to sustain attendance, it is necessary that the medication below be given during school hours.

Name of Medication: One med per form.

Generic substitution permitted or comparable brand is acceptable circle one: YES NO Provider's Initials _____

Route-Circle One: Tablet Capsule Liquid Inhaler Nebulizer Patch Drops Injection Rectal Other: _____

Dosage (amount to be given) _____

Time/Frequency: ____ A.M. ____ P.M. or Lunchtime: (please circle one) WITH BEFORE AFTER lunch

OR As Needed Every ____ hours

Reason for Medication: _____

Side Effects (most common): _____

Termination Date: _____ (Unless an earlier end date is provided, medication orders remain valid throughout the current school year including summer programs and activities. All orders must be renewed at the start of each school year.)

Medical Provider Signature: _____ Date: _____

Medical Provider Name Printed: _____ Telephone #: _____

Provider Stamp here if available:

HEALTHCARE PROVIDER Authorization for student named above to self-administer medication. The student has been instructed in the treatment plan and self-administration of the listed medication and has demonstrated the knowledge and skill necessary to self-administer this medication. I have determined that adult supervision is not needed.

Student should be allowed to self-carry and administer this medication: YES NO Provider's Initials: _____

Parent Authorization: Please sign the authorization that applies to your child, see below or see page 2.

Parent permission for medication to be administered by the school nurse/staff:

- I hereby give my permission for my above named child to receive medication during school hours.
- This medication has been prescribed by a licensed medical provider.
- I hereby release the School Board, their agents, and employees from all liability that may result from my child taking the prescribed medication.
- This consent is good for the school year, unless written notification to discontinue is received from the healthcare provider or parent/guardian.
- Medications must be delivered to the school by parent/guardian.
- I will furnish all medication and necessary supplies for medication administration at school.
- Prescription medications must be in a container with a pharmacy label with information that matches the above order (name of child, medication name, dosage, and the time it is to be given or taken).
- I will furnish a pill crusher for medications that must be crushed to administer.
- If it is necessary to cut tablets to meet the dose prescribed, I will furnish pre-cut tablets.
- I understand that expired medications cannot be administered at school.

Parent/Guardian Signature: _____ Phone: _____ Date: _____



*****Self-administered medications, parent signatures required, see second page*****

School Nurse Reviewed: _____ Date: _____

Medication Authorization for Students with Self-Administered Medications

Student's Name: _____ Date of Birth: _____ Date: _____

School Year: _____ Teacher/Home Room: _____ Grade: _____

Name of Medication to be Self-Administered: _____ Date of Order: _____

Medical Provider Authorization attached: YES _____ Self-Administered Initialed: YES _____

Parent Permission for medication to be SELF-ADMINISTERED by their child (K-5 consult with School Nurse):

- I agree to the attached medication authorization as written by my child's medical provider.
- I hereby request that my child be allowed to carry and self-administer the medication at school as prescribed by my child's licensed health care provider.
- I understand my child must carry this medication at all times in school or he/she will lose the right to carry it. I further understand that the school undertakes no responsibility for the administration of the medication.
- I hereby release the School Board, its agents and employees, from any and all liability that may result from my child taking this medication.
- My child is knowledgeable about this medication and how to self-administer it.
- I understand it is my responsibility to provide a backup supply of emergency medications to be stored at school with the nurse.
- I agree to ensure that the medication will have a pharmacy label that matches the attached order and is not expired.

Parent/Guardian Signature: _____ Phone: _____ Date: _____

Student Contract for Self-Administered Medication

Student Responsibilities:

- o I plan to keep my inhaler, equipment, epinephrine or other medication with me at school rather than in the school nurse's office
- o I agree to use my inhaler, equipment, epinephrine or other medication in a responsible manner, in accordance with my licensed health care provider's orders
- o I will notify the school health office or main office if I am having more difficulty than usual with my health condition
- o I will not allow any other person to use my inhaler, equipment, Epi-pen or other medication
- o I will carry the least amount of medication possible in its original container

Student Signature: _____ Date: _____

School Nurses Responsibilities:

- o Emergency Action Plan complete and on file at school, if applicable
- o Observe that student has demonstrated correct use/administration of medication
- o Student acknowledges proper and prescribed timing for medication
- o Indicate the method to carry medication or keep in an established location: _____
- o Student can verbalize understanding of health condition
- o Recommend a second labeled medication to be kept in the health room
- o Review with students the importance of not sharing medication or equipment with others
- o

Comments: _____



School Nurse Reviewed: _____ Date: _____