

South Harrison Community School Corporation

Medication Authorization/Administration Form

Guidelines:

1. All medication, both prescription and non-prescription, to be used during the school day must be given to the school nurse or her designee at the start of the school day.
2. This form must accompany the medication and must be completed and signed by a parent/guardian and the healthcare provider (physician, dentist, or nurse practitioner).
3. A new form must be completed each new school year and each medication must be on its own form. 4. All medications must be kept in the original container, prescription medication must be in a pharmacy bottle labeled correctly with the dosage and times to give matching the physician's order on this form. The student's name must be on the bottle.
5. Any change in medication, dosage, or time to be given must be given in written form with the parent and health care provider's signature.
6. Medications are kept under lock and key and are dispensed by the school nurse or her designee unless the physician has ordered it to be self-administered.
7. Parents must pick up remaining medication within one week of termination of an order or within one week of the end of the school year or the medication will be destroyed in the presence of a witness.

Student: _____ Date of Birth _____

TO BE COMPLETED BY THE PHYSICIAN:

Medication to be given: _____

Dosage to be given: _____

Time of Day to be given: _____

Condition being given for: _____

Start Date: _____ Stop Date: () End of School Year () Other _____

Special Instructions:

() For **Emergency Meds** (i.e. inhalers, epi-pens, glucose tablets, etc.). This medication is to be self-administered by the student. He/she has been instructed in how to self-administer the medication and may carry the medication on his/her person.

() This medication is to be self-administered by the student. He/she has been instructed in how to self-administer the medication. This medication will be kept in the nursing office.

() Please observe for the following adverse reactions _____

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Physician's Phone
Number: _____ Physician's Address/City/State/Zip: _____

TO BE COMPLETED BY THE PARENT:

I request, authorize, and give permission for the above named student to receive medication during the school day as indicated. I authorize school personnel to exchange information regarding this medication with the healthcare provider listed above and/or the dispensing pharmacy.

Parent/Legal Guardian Signature: _____ Date: _____

Medication was given on dates as initialed.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
July																															
Aug																															
Sep																															X
Oct																															
Nov																															X
Dec																															
Jan																															
Feb																													X	X	
Mar																															
Apr																															X
May																															
Jun																															X

Name: _____ Initials: _____ Name: _____ Initials: _____

Name: _____ Initials: _____ Name: _____ Initials: _____

Each time medication is brought to the school the amount of medication brought in and who brought it in will be recorded.

Date	Amount	By Whom	Date	Amount	By Whom

At the end of the school year a letter will be sent to the parent/guardian to pick up the medication. If it is not picked up by the date indicated on the letter the medication will be destroyed in the presence of a witness.

Date Letter Sent: _____ Date to be picked up by: _____

Date Picked Up: _____ Amount: _____ By Whom: _____

Signature of person taking medication: _____

() Letter from parent to send home with student (9th-12th grades). Attach letter to this form.

() Medication destroyed. Date: _____

School Nurse: _____ Witness: _____