SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

School Year: _____ Including Summer Session

School: _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- 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.
- An adult must bring the medication to the school.

PRESCRIBER'S AUTHORIZATION

Name of Student: _____

Date of Birth: _____

Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____

Dose: _____

Route: _____

Time/Frequency of Administration: _____

If PRN, Frequency: _____

If PRN, For What Symptoms: _____

Relevant Side Effects:

☐ None expected ☐ Specify: _____

Medication shall be administered from: _____

to: _____

Prescriber's Name/Title (Type or Print): _____

Telephone: _____

FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____

(Original signature or signature stamp ONLY)

PARENT/GUARDIAN AUTHORIZATION

I/We request designated 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 the school year, an adult must pick up the medication, otherwise it will be discarded.

I/We authorize the school nurse to communicate with the health care 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 Nurse Program medication policy.

Prescriber's authorization for self carry/self administration of medication:

_____

_____

School Official Approval for self carry/self administration of medication:

Signature: _____

Date: _____

FOR SCHOOL USE

Date Received: _____ Received By: _____

Medication Verified: ☐ Yes ☐ No Container/Label Verified: ☐ Yes ☐ No

School Nurse Notified: ☐ Yes ☐ No Self-Carry Approval: ☐ Yes ☐ No ☐ N/A

Notes: _____