Bus Route: ____ School Year ___-___

# Medication Administration Authorization (MAA)

**Student's Name: _____ DOB: _____ School: _____Grade: _____**

**1st Contact Name: _____ Phone: _____**

**2nd Contact Name: _____ Phone: _____**

***This form must be <u>FULLY COMPLETED</u> in order to administer the required medication. It is valid for one school year (August- June) and must be updated by a physician if any changes are made to the student's treatment. Prescription medication must be in its original container and labeled by the pharmacist. Non-prescription medication must be in the original container with the label intact.***

Name of Medication: _____ Reason: _____

Form: ☐Tablet/ capsule ☐Liquid ☐Inhaler ☐Injection ☐Nebulizer ☐Other_____

Dose:_____ Time to be given: _____ As needed/ PRN: _____

Additional Instructions: _____

Storage requirements: ☐None ☐Refrigerate Side effects: _____

Start date- if not beginning of school year :_____ Stop date- if not the end of the school year: :_____

- ☐ I request that the student be **assisted by authorized school personnel** in taking the described medication at school according to Board of Education Policy #5330
- ☐ I request that the **student be allowed to self-administer** the above medication at school according to school policy and is both capable/responsible.
- ☐ I request that the **student be allowed to self-carry the above medication** at school according to school policy (consider keeping spare dose in office) Location kept: _____

**Physician/Licensed Prescriber Name (Print):_____**

**Phone Number: _____ Fax Number: _____**

**Signature: _____ Date: _____**

**Parent/Guardian Name**: _____ **Date**: _____

**Signature: _____ Phone: _____**

*It is the parent/guardian responsibility to: replace expired medication; provide refills in the new original container when needed; transport the medication to and from the school office; and pick it up at the end of the school year. The school does not store medicine over the summer. No expired medication will be given.*