AUTHORIZATION FOR MEDICATION OR TREATMENT

This order is valid only for school year (current) _____ including the 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.
* The school nurse will call the prescriber, as allowed by HIPPA, if a question arises about the child and/or the child's medication.

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 _____
Month/Day/Year Month/Day/Year

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

Telephone:_____ FAX:_____

Address: _____

Prescriber's Signature:_____ Date:_____
(Original Signature Only)

(Use for Prescriber's Address Stamp)

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 parent/guardian and must be approved by the school nurse according to the school medication policy.

Prescriber's authorization for self-carry/self-administration of medication:_____
Signature/Date

Parent/Guardian authorization for self-carry/self-administration of medication:_____
Signature/Date

School Nurse approval for self-carry/self-administration of medication:_____
Signature/Date