

Administration of Medication Authorization Form

(to be completed by Physician)

Name of Student: _____

Date of Birth: _____ Grade: _____

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 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 (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

PRESCRIBER'S AUTHORIZATION

Diagnosis or reason for medication: _____

Medication Name: _____ Dose: _____ Frequency: _____

Self Carry/Administration Authorized: Yes No

Any special instructions: _____

Relevant side effects: None expected Specify: _____

Medication shall be administered from: _____ to _____

Month / Day / Year

Month / Day / Year

Medication Name: _____ Dose: _____ Frequency: _____

Self Carry/Administration Authorized: Yes No

Any special instructions: _____

Relevant side effects: None expected Specify: _____

Medication shall be administered from: _____ to _____

Month / Day / Year

Month / Day / Year

Medication Name: _____ Dose: _____ Frequency: _____

Self Carry/Administration Authorized: Yes No

Any special instructions: _____

Relevant side effects: None expected Specify: _____

Medication shall be administered from: _____ to _____

Month / Day / Year

Month / Day / Year

Is Epinephrine Auto Injector self carry/administration authorized? Yes (Dosage _____) No

Prescriber Physician's Name: _____

Prescriber's Signature: _____ Date: _____

Telephone: _____ FAX: _____ Email _____

Address: _____

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 or designated health coordinator 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 EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse or designated health coordinator according to the State medication policy.

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

Signature: _____ Date: _____

School nurse or designated health coordinator approval for self carry/self administration of emergency medication:

Signature: _____ Date: _____