

## School Medication Administration Authorization Form

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ School Year: \_\_\_\_\_

**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 medication administration.**

- ◆ Prescription medication must be in a container labeled by the pharmacist or prescriber.
- ◆ Non-prescription medication must be in the original packaging with the label intact and student's name.
- ◆ A parent/guardian **must** bring the medication to school. Students **are not** permitted to bring medication to school.
- ◆ The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or child's medication.

### ◆ PRESCRIBER'S AUTHORIZATION ◆

(this section must be completed by the prescriber)

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: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Medication shall be administered from: \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_  
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

Date: \_\_\_\_\_

A verbal order was taken by the school nurse, \_\_\_\_\_ for the above medication on \_\_\_\_\_  
 or designated personnel (name) (date)

\_\_\_\_\_  
 Signature

### ◆ 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 properly discarded. I/We authorize the school nurse to communicate with the health care provider or prescriber as allowed by HIPAA.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_