Baden Academy Charter School
School Medication Authorization Form

This order is valid only for school year (current)________________.

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 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

Name of student: ______________________ Date of Birth: ____________ Grade: ______.

Condition for which medication is being administered: ____________________________.

Medication name: ______________________ Dose: ____________ Route: __________.

Time/frequency of administration: ____.

If PRN, for what symptoms; ____.

Relevant side effects: ____ None expected ______ Specify: ______________________.

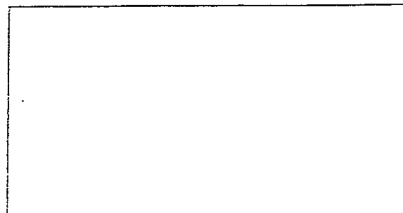
Medication shall be administered from: __________________ to __________________.
Month/day/year Month/day/year

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

Telephone: ______________________ Fax: ____________

Address: ____

____



(Use for Prescriber's Address Stamp)

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#: ______________.