SCHOOL MEDICATION AUTHORIZATION FORM

This order is valid only for the current school year: 20 _____ — 20 _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed (1) at the beginning of each school year, (2) for each medication, and (3) each time there is a change in the dosage of administration of a medication.

Prescriber's authorization: ____

Student's name: ______________________________ Date of birth: _____ / _____ / _____

School: ______________________________________ Grade: ___________

Condition for which medication is being administered: ____________________________

Name of medication: ___________________________________ Dose: __________

Time/frequency of administration: ____________________________ Route: ________

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 and title: ____

Telephone: (______) ________ - __________ Fax: (______) ________ - __________

Address: ____

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 HIPPA.

Parent/Guardian Signature: ______________________________ Date: _____ / _____ / _____

Home Phone: (______) _______ - __________ Cell/Work Phone: (______) ________ - __________