**School Medication Administration Authorization Form**

This order is valid only for school year (current) \_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form must be completed in full for the school nurse and staff to administer the required medication. A new form must be completed at the beginning of each school year and whenever 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/box with the label intact.**

**\* A parent/guardian must bring all controlled substances directly to the school nurse.**

Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade: \_\_\_\_\_\_\_

| Medication Name | Route  | Dosage and Frequency  | Reason for administration | Special Instruction / Side effects  |
| --- | --- | --- | --- | --- |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |

Prescriber’s Name/Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION**

I request designated school personnel to administer the medication as prescribed by the above provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I have read and will comply with the Mandatory Medication Guidelines (located on school website).

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

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

**Order Reviewed by the School Nurse:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_