South Middleton School District Medication Administration Authorization Form

This order is valid only for school year_________________ including the summer session.

This form must be completed fully for school personnel to administer the required medication. A new medication administration 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 CSN/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:___________________________________ DOB: _________________ Grade: _________________

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: ____

Medication shall be administered from: ________________________________ to: _____________________________
Month/Day/Year

Prescriber's Name/Title: ____
(Type or Print)
Telephone: ________________________ Fax: _____________________________
Address: ____
____

Prescriber's Signature: _______________________ Date: ___________________
(Original signature or signature stamp only)

(Prescriber's address stamp)

A verbal order was taken by the CSN/RN (Name): ____________________for the above medication on (date): ___________

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 the 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, and 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 #: __________________

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 according to the State medication policy.

Prescriber's Authorization for Self-Carry/Self Administration of emergency medication: ____
Signature/ Date

CSN/RN approval for Self-Carry/ Self Administration of emergency medication: ____
Signature/ Date

Order reviewed by CSN/RN: ____
Signature/ Date