

**School Nurse Program  
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM**

This order is valid only for school year (current) \_\_\_\_\_ including the summer session.

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 the 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, frequency: \_\_\_\_\_

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: \_\_\_\_\_

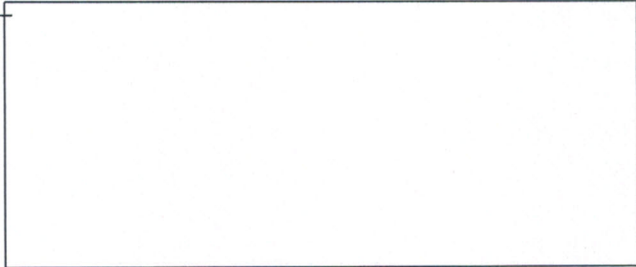
(Type or print)

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

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

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Original signature or signature stamp ONLY)



(Use for Prescriber's Address Stamp)

**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 #: \_\_\_\_\_

**SELF CARRY/SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL**

Self carry/self administration of medication (including **emergency medication**) may be authorized by the prescriber and must be approved by the school nurse according to the School Nurse Program medication policy.

Prescriber's authorization for self carry/self administration of medication: \_\_\_\_\_  
Signature Date

School RN approval for self carry/self administration of medication: \_\_\_\_\_  
Signature Date

Order reviewed by the school RN: \_\_\_\_\_  
Signature Date