DILLER-ODELL SCHOOLS
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

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

This form must be completed fully in order for the school 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 or other authorized school personnel will call the prescriber, as allowed by HIPPAA, 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 expected: ___ NO ___ Yes Specify: _____

Medication shall be administered from (dates): _____

Prescriber's Name/Title: _____

Telephone: _____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____

Date: _____

(Use for Prescriber's Address Stamp ↑)

PARENT/GUARDIAN AUTHORIZATION

Please initial:

_____ I/We request designated school personnel to administer the medication as prescribed by the above prescriber.
_____ I/We request that our child be able to carry the above medication and to self administer this medication.

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. I/We authorize school personnel working with our child to be informed of our child's medical condition.

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Cell: _____ Work: _____

Date this medication brought to school: _____ Location of the medication: □ health office □ office □ classroom □ other _____

School Nurse Signature: _____ Date: _____