In the pursuit of excellence…

Caledonia Community Schools

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

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

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: _____

Allergies _____ 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: _____

Prescriber's Name/Title:_____

Telephone: _____ FAX: _____

Address:_____

Prescriber's Signature: _____Date:_____

(Original signature or signature stamp ONLY)

(Use for Prescriber's Address

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