



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

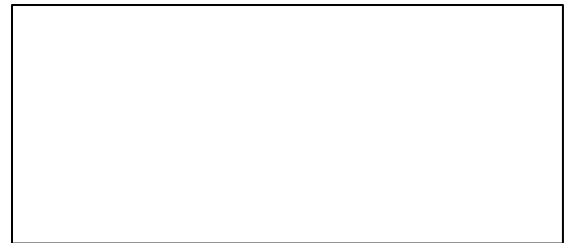
Prescriber's Name/Title: \_\_\_\_\_

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 \_\_\_\_\_