

# **Authorization for Administration of Medication at School**

Name of Student:	Birthdate:					
School:		School Year:			Grade:	
Medical Condition & ICD 10 Code	Medication Name and Strength	Dose	Time	Route	Possible Side Effects	
Other Considerations/Dire	ections:					
	edgeable about the medication (r				es)	
Start Date:	All authorizations ex	pire at end o	of the school	year unless r	noted:	
Print/Type Name of Physician/Licensed Prescriber		Physician's/Licensed Prescriber's Signature				
Clinic Name & Location Phone Num		per	Fax Number		 Date	
	PARENT/GUA	ARDIAN AL	JTHORIZA <sup>-</sup>	TION		
I request that the physician/license	above medication(s) be give d prescriber.	en during sch	nool hours as	ordered by t	his student's	
	medication(s) be given on fi	•	•			
	<ul><li>3. I release school personnel from liability in the event adverse reactions result from taking the medication(s).</li><li>4. I will notify the school of any change in the medication(s) such as dosage change, discontinued, etc.</li></ul>					
•	, ,	` ,		•	iscontinued, etc.	
• .	at arise with regard to the list			•		
medication(s).	Ŭ		( )		, , ,	
6. I give permission	for the medication(s) to be g	iven by desi	ignated perso	onnel as dele	gated by the School Nurse.	
☐ My child may se	elf-administer their medica	tion (not ap	plicable for	controlled s	substances)	
	Parent/Guardian Signature		Relat	Relationship to Student		

Note: MEDICATION MUST BE SUPPLIED IN THE ORIGINAL/PRESCRIPTION BOTTLE & CANNOT BE EXPIRED



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### **MEDICATION PROCEDURE**

The purpose of administering medications in school is to assist students who require medication to be taken or administered during school hours to maintain an optimal state of health, therefore, enhancing their educational program.

The intent of this procedure is to assure safe administration of medications in school for those students who require them. This procedure applies to both prescription and over-the-counter medication.

A written statement shall be required <u>annually</u>.

### LONG-TERM MEDICATIONS: Prescribed for more than two weeks

- 1. A written statement is required:
  - a. From the physician indicating the name of the medication, the route, the dosage, frequency and time of administration, reason the medication needs to be given (diagnosis), possible side effects, and termination date.
  - b. From the parent requesting and authorizing the school to give the medication in the dosage prescribed by the physician.
- 2. Parents/guardians are required to supply the medication in the original container labeled by the pharmacy or physician. The container will be labeled with the student's name, name of the medication, dose to be given, frequency and time it is to be given, the name of the prescribing physician and the date the medication was obtained.

#### SHORT - TERM MEDICATIONS: Prescribed for less than two weeks

- 1. A written statement will be required from the parent/guardian giving permission to give the medication in school. The statement must include: the name of the medication, the reason for the medication, the route, the dosage, the time and date the medication is to be given.
- 2. Parents/guardians are required to supply the medication in the original container labeled by the pharmacy or physician. The container will be labeled with the student's name, name of the medication, dose to be given, frequency and time it is to be given, the name of the prescribing physician, and the date the medication was obtained.