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 I Day / Year Month I Day I Year

Prescriber's Name/Title: Joy Inyang, MD

(Type or print)

Telephone: 810-632-3200 FAX: 810-632-3230

Address: 10850 Highland Road

Hartland, MI 48353

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